Manulife

doctors of bc

Fourth Year Student Increase Disability Election Form

1. Personal information

Member ID number:

Last Name: | First Name: | Middle Initial:

Date of Birth (dd/mm/yy): | Mailing address (street number or name):

Apartment or Suite: | City:

Province: | Postal Code:

Email (optional):

2. Disability insurance

☐ Increase my disability insurance benefit to $4,000/month

3. Other Insurance Information

Do you have any pending or existing disability insurance with Manulife or any other company?

☐ Yes ☐ No (If yes, provide full details below)

$ | Insuring Company | Date of Issue (mm-yyyy)

Will any disability insurance be replaced if the coverage you applied for is issued?

☐ Yes ☐ No (If yes, provide full details below)

Insuring Company | $)

4. Declaration and Authorization

I declare that the statements contained in this application are true and complete. I understand that any material misrepresentation shall render the insurance voidable at the instance of the insurer.

I, the undersigned person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose. I authorize Manulife to hold a personal file about myself and my insurance coverage. I authorize Manulife, the plan administrator, and their authorized staff, agents, representatives, advisors and service providers to use and exchange information needed for underwriting, financial management, administration and adjudication of claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers. A photocopy or faxed copy of this authorization shall be as valid as the original.

I acknowledge my receipt of and agreement with the Notice on Privacy and Confidentiality.

Signed at (city or town): | Signed at (province):

Date (dd-mm-yyyy): | Signature:

Underwritten by The Manufacturers Life Insurance Company (Manulife).