Manulife

doctors of bc

Application for Life Insurance

For the members of Doctors of BC or the Yukon Medical Association, and/or their spouses

In this application, "we", "us", and "our" refer to the Manufacturers Life Insurance Company. "You" and "your" refer to the person to be insured.
Doctors of BC may be reached toll-free at 1-800-665-2262 ext. 2904 or on their website at **doctorsofbc.ca**.

1. Member information

*A non-smoker is someone who has not used any form of tobacco or tobacco cessation products, including the use of e-cigarettes or vaporizers within the past 12 months.

Doctors of BC#:

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth: (dd-mm-yyyy):

Province of birth: Country of birth:

Email (optional):

Mailing address (street number and name):

Apartment or Suite: City:

Province or Territory: Postal Code:

Telephone (residence): Telephone (business):

Fax: Telephone (cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

1.1 Contact preference

May we correspond with you via email so that we may contact you for the administration of this application?

☐ Yes ☐ No

Preferred phone number and time to contact member:

☐ Residence ☐ Business ☐ Cell

☐ Monday to Friday	☐ Saturday	☐ Sunday
☐ Morning (6:00–12:00)	☐ Morning (6:00–12:00)	☐ Morning (6:00–12:00)
☐ Afternoon (12:00–5:00)	☐ Afternoon (12:00–5:00)	☐ Afternoon (12:00–5:00)
☐ Evening (5:00–10:00)		

1.2 Spouse information

Complete this section if you are a spouse applying for coverage.

*A non-smoker is someone who has not used any form of tobacco or tobacco cessation products, including the use of e-cigarettes or vaporizers within the past 12 months.

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth: (dd-mm-yyyy):

Province of birth: Country of birth:

Email (optional)s:

Telephone (residence): Telephone (business):

Fax: Telephone (cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

1.3 Spouse Contact Preference

Preferred phone number and time to contact member:

☐ Residence ☐ Business ☐ Cell

☐ Monday to Friday
- ☐ Morning (6:00–12:00)
- ☐ Afternoon (12:00–5:00)
- ☐ Evening (5:00–10:00)

☐ Saturday
- ☐ Morning (6:00–12:00)
- ☐ Afternoon (12:00–5:00)

☐ Sunday
- ☐ Morning (6:00–12:00)
- ☐ Afternoon (12:00–5:00)

1.4 Member occupational information

Complete this section if you are a member applying for coverage.

a) Medical Specialty:

b) Date initial medical practice commenced in Canada (if within the last two years) (dd-mm-yyyy):

1.5 Spouse occupational information

a) Occupation:

b) Are you actively at work for at least 20 hours per week? ☐ Yes ☐ No

If no, confirm whether you:

i) were hospitalized in the last six months? ☐ Yes ☐ No

ii) can perform the six activities of daily living (bathing, dressing, feeding, continence, toileting, transferring)? ☐ Yes ☐ No

c) Amount of annual income **$**

2. Coverage applied for (Member)

Telephone interview

A telephone interview will be required in order to assess your application. Manulife has selected a national support organization to conduct this interview. A carefully screened and trained interviewer will ask you a series of questions about your medical history, your doctor's name, and any medications taken. The interview will take approximately 30 minutes and be kept in strictest confidence. The information you provide will be used solely for insurance purposes and will be sent to Manulife promptly upon completion.

*For more information about the riders, visit the Doctors of BC website at **www.doctorsofbc.ca**.

Member Life insurance

Indicate the amount of coverage you are applying for at this time.
Maximum number of units = 100

Are you applying for: ☐ new coverage ☐ additional coverage

Level coverage	Waiver of Premium rider*	Future Insurance Option rider*
Number of units ____ x $50,000 = **$** ____	☐ Yes	☐ Yes

☐ Bill me ☐ Personally ☐ My corporation

2. Coverage applied for (Member) continued

Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary.

If no beneficiary is designated, benefits will be payable to the Estate.

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

2.1 Coverage applied for (Spouse)

Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary.

If no beneficiary is designated, benefits will be payable to the Estate.

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Indicate the amount of coverage you are applying for at this time.
Maximum number of units = 100

Are you applying for: ☐ new coverage ☐ additional coverage

Level coverage	Waiver of Premium rider*	Future Insurance Option rider*
Number of units ____ x $50,000 = **$** ____	☐ Yes	☐ Yes

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19
Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 19

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

3. Other Insurance Information

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance certificate. A replacement form or declaration may be required, and we may not be able to issue an insurance certificate where replacement is indicated.

a) Do you have any pending or existing life insurance coverage with Manulife, Doctors of BC or any other company?

☐ Yes ☐ No If yes, provide details below:

Name of applicant	Amount of benefit	Insuring company	Date of issue (mm-yyyy)
	$		
	$		
	$		
	$		
	$		
	$		
	$		
	$		

b) Will any insurance be replaced if this coverage you have applied for is issued?

☐ Yes ☐ No If yes, provide details below:

Insuring company	Amount
	$
Insuring company	Amount
	$
Insuring company	Amount
	$
Insuring company	Amount
	$

4. Declaration and authorization

I /We (the Member/Spouse) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I declare that the statements contained in this application, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any coverage issued hereunder. I understand that any material misrepresentation including misstatement of smoker status shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. I understand that insurance will take effect on the date my properly completed application is received by Manulife. I understand that there are exclusions and limitations on the coverage applied for.

Relative to the insurance applied for, 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 MIB Inc., 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 declare that I have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I understand that this consent may be revoked at any time and that, if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

I understand that in connection with this application, Manulife may request a medical examination, urinalysis, or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law.

I/We hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate or policy issued hereunder.

I/We acknowledge my/our receipt of and agreement with the Personal Information Statement and Notice of Exchange on Information.

If my/our application is approved, I/we will receive a certificate specifying the coverage provided and the main certificate provisions.

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

Date (dd-mm-yyyy):

Signature of member: | Signature of spouse:

Return completed application to:
Doctors of BC Insurance Department
115-1665 West Broadway
Vancouver BC V6J 5A4

or Fax: 1-604-638-2909

or scan and email to: insurance@doctorsofbc.ca

5. Notice of Exchange of Information

Information about MIB, Inc.

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, Inc. is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at:

MIB, Inc.
330 University Avenue, Suite 501 Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

6. Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our," and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to **www.manulife.ca**.

We collect, use, verify, and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, or driver's license
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test.
- Your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- A copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report, and/or a consumer report from other organizations, person, or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics, and interests
- Other personal information we may require to administer our business relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company
- Other sources, such as: Your advisor or authorized representative(s)
- Third parties with whom we deal in issuing and administering your policy now, and in the future
- Public sources, such as government agencies and internet sites

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you.

Who do we disclose your information to?

- Persons, financial institutions, and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents, and representatives
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical, and investigative agencies)
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The above mentioned people, organizations, and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:

- will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:

- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain, or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care center at 1-888-MANULIFE (626-8543), or 1-888-MANUVIE (626-8843) in Quebec, or write to the Privacy Officer at the address below.

Accuracy and Access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer Manulife, P.O. Box 1602, 500 King Street N Waterloo, ON N2J 4C6
Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email, you are authorizing us to communicate with you by email.

Underwritten by The Manufacturers Life Insurance Company (Manulife).

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