doctors of bc
British Columbia Medical Association

Application for Insurance

Sun Life Financial

For the members of Doctors of BC and/or their spouse

In this application *you* and *your* refer to the person applying for insurance. *We* and *the Company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Please PRINT clearly.

1 Member/spouse/child information

Doctors of BC #
MSP number

Preferred place and time to contact member:

Place
☐ Residence
☐ Business
☐ Cell

Day
☐ Weekdays
☐ Weekends

Time
☐ Morning (8:00-12:00)
☐ Afternoon (12:00-5:00)
☐ Evening (5:00-8:00) (Friday 6:00)
☐ Saturday (8:00-1:00)

Preferred place and time to contact spouse:

Place
☐ Residence
☐ Business
☐ Cell

Day
☐ Weekdays
☐ Weekends

Time
☐ Morning (8:00-12:00)
☐ Afternoon (12:00-5:00)
☐ Evening (5:00-8:00) (Friday 6:00)
☐ Saturday (8:00-1:00)

Member information

Last name	First name	Middle initial	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Province of birth	Country of birth
Email address	☐ Non-smoker ☐ Smoker *Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		
Mailing address (street number and name)			Apartment or suite
City		Province	Postal code
Telephone (residence)	Telephone (business)	Telephone (cell)	Fax

Spouse information (if applying for Spouse Life or Spouse Critical Illness insurance)

Last name	First name	Middle initial	☐ Male ☐ Female
Former/maiden name (if applicable)	Date of birth (dd-mm-yyyy)	Province of birth	Country of birth
Email address	☐ Non-smoker ☐ Smoker *Non-smoker* means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.		
Telephone (residence)	Telephone (business)	Telephone (cell)	

Child information (if applying for Child Critical Illness insurance)

Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	Gender
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

If additional space is required, please attach a signed and dated sheet of paper with the required child information

DC-100

2 Member occupational information

Please complete this section only if you are a member and applying for coverage.

a) Medical specialty

b) Are you self-employed? ☐ Yes ☐ No If *yes*, business structure: ☐ Sole proprietor ☐ Partnership ☐ Corporation % ownership

If *no*, name and address of employer

c) Date initial medical practice commenced in Canada: dd-mm-yyyy

d) Numbers of hours worked per week in the practice of medicine:

If less than 30, please explain why

e) Numbers of weeks worked per year in the practice of medicine:

If less than 46 weeks per year, please explain why

f) Have you changed your job duties, location and/or hours of work in the past two years, or do you contemplate such changes within the next year?

☐ No

☐ Yes If *yes*, please describe.

3 Spouse occupational information

Please complete this section only if your spouse is applying for coverage.

a) Your spouse's occupation

b) Amount of annual income

$

c) Is your spouse actively at work for at least 20 hours per week?

☐ Yes ☐ No

If no, please confirm whether your spouse:

i) was 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

4 Coverage applied for (please refer to the brochure for eligible amounts and benefits)

Please indicate the amount of coverage you are applying for at this time, **excluding existing Doctors of BC coverage, if any.**

Maximum number of units = 100

Member Life insurance

Level coverage	Waiver of Premium rider*	Future Insurance Option rider*
No. of units _____ x $50,000 = $	☐ Yes	☐ Yes

Beneficiary designation

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

PRIMARY beneficiary or beneficiaries – Share of benefits must add up to 100%.

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

CONTINGENT beneficiary or beneficiaries – Share of benefits must add up to 100%.

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

Any amount payable to a child appointed above during (his/her) minority shall be paid to the following as trustee for such child:

Trustee clause for minor children – applies when beneficiary is under age 19.

Last name of trustee	First name	Middle initial	Relationship to life insured

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

Please indicate the amount of coverage your spouse is applying for at this time, **excluding existing Doctors of BC coverage, if any.**

Maximum number of units = 100

Spouse Life insurance

Level coverage	Waiver of Premium rider**	Future Insurance Option rider**
No. of units _____ x $50,000 = $	☐ Yes	☐ Yes

Beneficiary designation

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

PRIMARY beneficiary or beneficiaries – Share of benefits must add up to 100%.

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

CONTINGENT beneficiary or beneficiaries – Share of benefits must add up to 100%.

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

Any amount payable to a child appointed above during (his/her) minority shall be paid to the following as trustee for such child:

Trustee clause for minor children – applies when beneficiary is under age 19.

Last name of trustee	First name	Middle initial	Relationship to life insured

Member Critical Illness (CI) insurance

Minimum $50,000
Maximum $250,000
in units of $10,000

Amount of insurance applied for at this time (excluding existing Doctors of BC coverage, if any)	Waiver of Premium rider**
$	☐ Yes

Spouse Critical Illness (CI) insurance

Minimum $50,000
Maximum $250,000
in units of $10,000

Amount of insurance applied for at this time (excluding existing Doctors of BC coverage, if any)	Waiver of Premium rider**
$	☐ Yes

4 Coverage applied for (continued)

Dependent Child Critical Illness (CI) insurance

Amount of new insurance applied for at this time

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

Member Professional Expense Insurance

Minimum $500/month in units of $100

Plan 14 maximum is $11,000/month

Combined maximum for all plans is $20,000/month

Amount of insurance applied for at this time (excluding existing Doctors of BC coverage, if any)			
$ 14 days	$ 30 days	$ 60 days	$ 90 days

☐ Yes, I am applying for the Guaranteed Insurability Benefit rider

Member Disability Income insurance

Minimum $500/month
Maximum $12,000/month in units of $100

Amount of insurance applied for at this time (excluding existing Doctors of BC coverage, if any)			
$ 28 days	$ 60 days	$ 90 days	$ 120 days

Please indicate the optional riders** applied for at this time:

☐ Own Occupation
☐ Cost of Living Adjustment
☐ Guaranteed Insurability Benefit
☐ Retirement Protection: ☐ $500 monthly contribution benefit ☐ $1,000 monthly contribution benefit

Physicians' Disability insurance (PDI)

☐ **Yes, I am applying for PDI coverage.**

The provincial government provides funding for this benefit. The premium paid on your behalf is a taxable benefit to you.

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

5 Financial information (complete if applying for Member Disability or Member Professional Expense Insurance)

	Current year-to-date from __-__-____ (mm-yyyy) to __-__-____ (mm-yyyy)	**Actual last year** __-__-____ (mm-yyyy)
Gross annual income before business expenses **(A)**	$	$
Less annual total of all your business expenses **(B)**	$	$
Net annual income before tax **(A) - (B)**	$	$

Is any portion of your income from a salaried position? ☐ Yes ☐ No	If *yes*, please provide salary $

Do you have unearned income, not dependent on your ability to work, in excess of $10,000 per annum (e.g. net investment income from securities, banks, real estate etc.) ☐ Yes ☐ No

If *yes*, amount $ _____

Source of unearned income _____

Have you ever declared or are you contemplating bankruptcy? ☐ Yes ☐ No

If *yes*, date of discharge (dd-mm-yyyy) __-__-____

6 Financial documentation

If you do not have an accountant, please enclose the financial documentation with the application.

Accountant's name	
Address	
Telephone number – –	Fax number – –
Email	

☐ I am enclosing the required documentation, **or**

☐ Please contact my accountant to obtain the required income documentation.

If you are applying for Member Disability Insurance, financial documents are required to confirm your income unless you are in residency, completed a fellowship or have commenced practice in the last two years in Canada.

The following income documentation will be required depending on your financial reporting situation:

Employee (Salaried)	Sole Proprietor or Partnership	Incorporated
• Most current T4 • Income Tax Return (Pages 1 to 4)	• Income Tax Return (Pages 1 to 4) • Statement of Business or Professional Activities (T2125)	• Most current T4 • Personal Income Tax Return (Pages 1 to 4) • Business Financial Statements of the Corporation

If you are applying for Member Professional Expense Insurance that exceeds a total of $10,000 per month, financial documents are required to confirm your expenses.

The following income documentation will be required depending on your financial reporting situation:

Sole Proprietor or Partnership	Incorporated
• Statement of Business or Professional Activities (T2125)	• Business Financial Statements of the Corporation

7 Insurance information

Please complete this section so that we may assess your insurable interest. Incomplete applications will be returned.

Do you or your spouse currently have insurance or have you or your spouse concurrently applied for any sickness or accident (including Disability insurance through your employer), Professional Expense Insurance, Critical Illness or Life insurance coverage provided by individual or group policies, or employment contracts/ partnership agreements (other than Doctors of BC or PDI insurance)?

☐ Yes ☐ No If *yes*, please provide details below.

Name of applicant	Amount of benefit	Type of coverage (Disability, OOE, Life,CI)	Insuring company	Date of issue (dd-mm-yyyy)	Benefit period	Taxable
	$			– –		☐ Yes ☐ No
	$			– –		☐ Yes ☐ No
	$			– –		☐ Yes ☐ No

Will any insurance be discontinued if the coverage you have applied for is issued?

☐ Yes ☐ No If *yes*, please provide details below.

Insuring company	
Type of coverage	Amount $

IMPORTANT: DO NOT CANCEL ANY EXISTING COVERAGE UNTIL THE COVERAGE YOU HAVE APPLIED FOR HAS BEEN APPROVED.

Please turn over

8 Declaration and authorization

Please read and sign this section.

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application will cause the insurance to be void. MEMBER ONLY: I also certify that as a member of Doctors of BC or Yukon Medical Association, I understand and agree that this application is void unless I am in active practice in Canada on the date of this application.

I hereby certify that I have read and understood the Medical Information Bureau (MIB) notice in section 9, and I have, by my signature below, authorized the MIB to give to Sun Life Assurance Company of Canada, or its reinsurers, any information it may have.

I authorize Sun Life Assurance Company of Canada, its agents and service providers including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers including the plan administrator to use and exchange relevant information about me in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage.

A photocopy or electronic version of this authorization is as valid as the original.

Signature of member	Signature of spouse (if applying for coverage)	
X	X	
Signed at (city)	Signed at (province)	Date (dd-mm-yyyy)
		– –

We retain the right to request financial information and/or a medical examination, urinalysis or tests such as a blood profile (including a blood test for HIV) which will be made at no expense to you. You may be contacted by a representative of the Company for your medical history.

Please mail your completed application to:

Doctors of BC Insurance Department
115-1665 West Broadway
Vancouver BC V6J 5A4

or FAX it to: 604-638-2909

or scan and email to:
insurance@doctorsofbc.ca

9 Medical Information Bureau notice

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you to its reinsurers. Sun Life Assurance Company of Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sun Life Assurance Company of Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to the MIB at:

Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7

or call: 416-597-0590

10 Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.