



Options Form Resident to Practicing Physician

(Past 90 Days but within 12 months of Residency Completion)

1 – Personal Information			
	First Name:	Middle Initial:	Gender:
Birthdate: MM / DD / YYYY	Province of Birth:	Country of Birth:	
Address:	City	Province	Postal Code
Phone:	Email:		
Doctors of BC #:	MSP Billin	ng #:	
2 - Residency program infor	mation		
Specialty:	Program Co	ompletion Date:	/YYYY
3 - Disability insurance			
· ·	ınt and riders currently in place	•	•
	ler(s):		
	coverage and riders will be payable	e from the 1 st of the month following	ng your residency
program completion date.	•		
☐ Reduce my coverage to			
☐ Cancel my disability insu	rance entirely		
-	surance (PDI) sional, MSP and/or service contract This insurance requires a full applic	=	_
☐ I would like to apply for F	PDI coverage with proof of good	d health	
Best phone number to reac	h you for a telephone interview		
☐ Phone numb	per listed above		
☐ Other:			
	a telephone interview:		
☐ I will not be applying for			
6 – Insurance Consultation F	<u> </u>	est me to review	ana na ada
□ Please have a Doctors of B	U licensed insurance advisor conta	act me to review my overall insura	anceneeus

5 - Declaration and Authorization

I understand that Doctors of BC will use this form to make changes to my existing disability insurance and that changes will be effective the 1st of the month following residency program completion date. I agree to pay back premiums that are due.

I understand if I cancel any of the above insurance programs and wish to reapply at later date, coverage will not be automatic and I will be required to provide proof of good health at that time.

I declare that my answers on this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

As a member of Doctors of BC or the Yukon Medical Association, for the addition of coverage using the GIB option, I understand and agree that (a) if approved, the GIB option amount will become effective on the date the application is received by Doctors of BC, but not prior to the date of the application Option period, (b) the new coverage will have the same exclusion(s) as specifically excluded from the Guaranteed Insurability Benefit Rider under the original coverage (c) the new coverage shall be subject to the terms of the Rider under which this option is being exercised.

For application to the Physicians' Disability Insurance Plan, I certify I am a member of the College of Physicians and Surgeons of British Columbia, that I receive remuneration from the Medical Services Plan on either a fee-for-service and/or sessional and/or non-salaried service contract basis and that I am aware of the terms and conditions of the Physicians' Disability Insurance plan for which I am applying. I agree that any insurance issued in consequence with this application shall not take effect unless, on the date the insurance would be effective, I am actively engaged in my regular occupation.

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

Signed at (city)	Signed at (province)	Date (MM/DD/YYYY)	
Signature			

Return by fax to 604-638-2909 or email to insurance@doctorsofbc.ca

Need help? contact our administration team at insurance@doctorsofbc.ca or (604)-638-290 (Toll Free: 1-800-655-2262).