Manulife

doctors of bc

Application for Individual Disability Insurance (with Evidence of Insurability)

For Doctors of BC Residents, use this form if you are applying more than 90 days after you began your residency in the province of British Columbia, or outside the open enrollment period. Otherwise, use the **Application for Doctors of BC Resident Individual Disability Insurance (without Evidence of Insurability)**.
In this application, **we, us** and **our** refer to The Manufacturers Life Insurance Company. **You** and **your** refer the person to be insured.

1. Member information

Doctors of BC#: MSP number:

Last Name: First Name: Middle Initial:

Date of Birth: (dd/mm/yy):

Province of birth: Country of birth:

Mailing address (street number or name):

Apartment or Suite: City:

Province: Postal Code:

Previous name (if you have used a different name in the last two years):

Email (optional): Fax:

Telephone (Residence): Telephone (business):

Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

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.

2. Contact Preference

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 medica-tions taken. The interview will take approximately 30 minutes and be kept in strictest confidence. The information you provide will be used solely for insurance purpos-es and will be sent to Manulife promptly upon completion.

Telephone interview:

A telephone interview will be required in order to assess your application.

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
- ☐ 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)

3. Program information

Date you started your program (dd-mm-yyyy):

Date your program is due to completed (dd-mm-yyyy):

Year of residency: ☐ R1 ☐ R2 ☐ R3 ☐ R4 ☐ R5 ☐ R6 ☐ R7 ☐ Fellowship

Location of your residency program (hospital and city):

Are you actively at work full-time at least 30 hours per week in your occupation? ☐ Yes ☐ No

If **no**, explain why:

4. Amount of Disability insurance applied for

A Resident or Fellow who maintains a minimum of $2,000 of coverage for at least 12 months immediately prior to completing their program, will not be required to provide evidence of insurability when applying for the government funded Physicians' Disability Insurance (PDI) plan within 90 days of starting their practice This insurance plan includes Guaranteed Insurability Benefit (GIB), Cost of Living Adjustment (COLA) and an Own Occupation definition of disability.

Tell us how much coverage you are applying for, excluding existing Doctors of BC coverage if any.

You may apply for an amount, or increase your coverage during the open enrollment period, from $500/month to the maximum based on your program year, in increments of $100:

- Program years 1-5: $4,000/month maximum
- Program years 6-7: $6,000/month maximum
- Fellowship: $7,500/month maximum

☐ Retirement Protection rider ($500/month)

☐ Retirement Protection rider ($1000/month)

☐ Retirement Protection rider ($1,500/month) available if you earn over $100,000 per year

5. Other insurance information

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

Do you have or have you concurrently applied for any other disability income insurance coverage other than with Doctors of BC?

☐ Yes ☐ No If yes, provide details below

Name of insurance company	Amount of monthly benefit	Date issued (mm-yyyy)	Taxable benefit?	Elimination period	Benefit period	Are you replacing coverage?
	$		☐ Yes ☐ No			☐ Yes ☐ No
	$		☐ Yes ☐ No			☐ Yes ☐ No

6. Declaration and Authorization

I 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 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.

6. Declaration and Authorization

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

Signed at (city or town, province): Date (dd-mm-yyyy):

Signature of member:

Please mail your completed application to the plan administrator:
Doctors of BC Membership Department115-1665 West Broadway Vancouver BC V6J 5A4

or Fax: 1-604-638-2909

or and email to:
insurance@doctorsofbc.ca

Underwritten by The Manufacturers Life Insurance Company (Manulife).

Please detach and retain for your records.
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 50 1 Toronto, Ontario M5G 1R7 Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

Notice on Privacy and Confidentiality

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Waterloo, ON N2J 4C6.