

Application for Student insurance

For the members of Doctors of BC and the Yukon Medical Association

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. General information

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

Last Name:	First Name:	Middle Initial:
Dr. <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/>		
Former Maiden Name (if applicable):	Date of Birth: (dd-mm-yyyy):	
Province of birth:	Country of birth:	
Address:	Apartment or Suite:	
City:	Province or Territory:	Postal Code:
Preferred telephone number:	Email (optional):	
Date you started medical school (dd-mm-yyyy):		
Date you expect to graduate (dd-mm-yyyy):		
What is your current year of medical school?	<input type="checkbox"/> First	<input type="checkbox"/> Second
	<input type="checkbox"/> Third	<input type="checkbox"/> Fourth
Medical school site:	<input type="checkbox"/> Vancouver (VFMP)	<input type="checkbox"/> Victoria (IMP)
	<input type="checkbox"/> Prince George (NMP)	<input type="checkbox"/> Kelowna (SMP)
<input type="checkbox"/> Non-smoker*	<input type="checkbox"/> Smoker	<input type="checkbox"/> Male <input type="checkbox"/> Female

2. Coverage applied for

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

If you are applying for Disability insurance, check the box. Your coverage will show based on your year of medical school.

Disability Insurance

Disability income:

First or Second year:

\$1,500 Monthly Benefit
COLA & GIB included*
HIV/Hepatitis /C Benefit*

Third year:

\$2,500 Monthly Benefit
COLA & GIB included*
HIV/Hepatitis B/C Benefit*

Fourth year:

\$2,500 Monthly Benefit
 \$4,000 Monthly Benefit
COLA & GIB included*
HIV/Hepatitis B/C Benefit*

If you are applying for Life insurance, check the box and provide beneficiary information.

Life insurance \$100,000 Level Term Insurance

3. 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.

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

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

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

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

4. 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.

Do you currently have Disability insurance or have you concurrently applied for any Disability insurance coverage provided by individual or group policies, or employment contracts or partnership agreements?

Yes No If yes, provide details below:

Amount of benefit	Insuring company	Date of issue (mm-yyyy)	Elimination period	Taxable
\$ _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Yes No If yes, provide details below:

Insuring company	Amount
	\$ _____
Insuring company	Amount
	\$ _____

5. Declaration and authorization

I (the Member) 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 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 have read the Pre-Existing Conditions Exclusions and 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 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 hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

I acknowledge my receipt of and agreement with the Personal Information Statement.

I 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:

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

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 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.

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.

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