

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 information

Doctors of BC #

Member information

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

Preferred place and time to contact member:

- Place** **Day**
- Residence Weekdays
 Business Weekends
 Cell

- Time**
- Morning (9:00-12:00)
 Afternoon (12:00-5:00)
 Evening (5:00-8:00)
 Night (8:00-11:00)

Spouse information (if applying for Spouse Life)

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

Preferred place and time to contact spouse:

- Place** **Day**
- Residence Weekdays
 Business Weekends
 Cell

- Time**
- Morning (9:00-12:00)
 Afternoon (12:00-5:00)
 Evening (5:00-8:00)
 Night (8:00-11:00)

2 Member occupational information

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

- a) Medical specialty
- dd-mm-yyyy
- b) Date initial medical practice commenced in Canada:
- c) Numbers of hours worked per week in the practice of medicine: _____
If less than 30, please explain why
- d) Numbers of weeks worked per year in the practice of medicine: _____
If less than 46 weeks per year, please explain why

3 Spouse occupational information

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

a) b)

c)
 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 = 60

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

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

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

Member Life insurance

Level coverage No. of units _____ x \$50,000 = \$	Waiver of Premium rider* <input type="checkbox"/> Yes	Future Insurance Option rider* <input type="checkbox"/> Yes
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Bill me Personally My corporation

Beneficiary designation

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

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:

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.

4 Coverage applied for (continued)

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 = 60

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

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

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

Spouse Life insurance

Level coverage No. of units _____ x \$50,000 = \$	Waiver of Premium rider** <input type="checkbox"/> Yes	Future Insurance Option rider** <input type="checkbox"/> Yes
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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.

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

5 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 Life insurance or have you or your spouse concurrently applied for any Life insurance coverage provided by individual or group policies, or employment contracts/partnership agreements?

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

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

Will any Life 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 LIFE COVERAGE UNTIL THE COVERAGE YOU HAVE APPLIED FOR HAS BEEN APPROVED.

6 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 7, 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 X	Signature of spouse (if applying for coverage) X	
Signed at (city)	Signed at (province)	Date (dd-mm-yyyy)

We retain the right to request 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

7 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

8 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.