Manulife

**The Manufacturers Life Insurance Company**
**Doctors Manitoba**
APPLICATION FOR INSURANCE

## Section 1: Applicant Information

Membership Number:

☐ Dr. ☐ Mr. ☐ Mrs. Last Name First Name Initial

Home Address Unit/Apt. City Province/ Territory Postal Code

Date of Birth DD/MM/YYYY Place of Birth (province, country) ☐ Male ☐ Female

Telephone (home or cell) Email (personal)

Business Address Unit/Apt. City Province/ Territory Postal Code

Telephone (business) Email (business)

Send mail to: ☐ Business ☐ Residence ☐ Smoker ☐ Non-Smoker*

*Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products, including e-cigarettes, in the past 12 months.

## Section 2: Amount of Insurance Requested

**I am applying for:** ☐ New coverage ☐ Additional coverage If currently insured under this plan, your certificate number:

### Disability Income Replacement (Do not include coverage already in force.)

These plans are not available to students; please request an application for the Student Disability Income Insurance.

2.1 Please indicate the monthly benefit amount you are applying for in $100 increments ((maximum $15,000): **$**

2.2 Choose an Elimination Waiting Period before benefits begin: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

2.3 Optional Riders: ☐ Own Occupation ☐ Cost of Living Adjustment ☐ Future Insurance Option (FIO)
☐ Retirement Protection Option **Coverage Amount** in $100 increments (minimum $300, maximum $1,000) **$**

### Office Overhead Expense

2.4 Please indicate the monthly total reimbursement benefit amount you are applying for in $100 increments (minimum $500, maximum $10,000): **$**

2.5 Choose an Elimination Period before benefits begin: ☐ 14 days ☐ 30 days
Note: In excess of amounts greater than $5500, the only EP option is 30 days

2.6 Choose a Benefit Period: ☐ 12 months ☐ 18 months

## Section 3: Other Insurance Information

3.1 Do you have any pending or existing disability income replacement or office overhead expense insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

| Company Name | Coverage Amount | Type of Insurance | Date Issued (Month/Year) | Elimination and Benefit Period | Taxable? | Will this coverage be replaced? |
|---|---|---|---|---|---|---|
| | $ | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | $ | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | $ | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | $ | | | | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Note:** If you intend to replace coverage (other than coverage you may have through an employer group benefits plan), do not cancel your existing coverage. In Quebec, a replacement form or declaration may be required. We may not be able to issue an insurance policy if replacement is indicated.

## Section 4: Accidental Death & Dismemberment Insurance

**Complete ONLY if you are applying for AD&D insurance**

Please indicate the coverage amount you are applying for in $10,000 increments (maximum $1000,000): **$**

If applying for new insurance, check one option: ☐ Member Only Plan ☐ Family Plan

For changes to existing insurance, check all appropriate boxes:

☐ Change in Amount ☐ Change to Member Only Plan ☐ Change of Name
☐ Change of Beneficiary ☐ Change to Family Plan ☐ Change of Address

**Note:** If you and your spouse are both eligible under the policy, only one may select the Family Plan with dependent children coverage.

### Beneficiary on the Applicant Death Benefit

I (the Applicant) hereby designate the individual(s) named below to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

**Beneficiary(ies):**

1. Last Name First Name

   Relationship to the Applicant % of Benefit

2. Last Name First Name

   Relationship to the Applicant % of Benefit

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 are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

**Trustee:**

1. Last Name First Name

   Relationship to the beneficiary % of Benefit

**For Quebec residents only:** Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable. (Check box below if designation is to be revocable.)

☐ I hereby declare and stipulate that the beneficiary designation made in this form is revocable.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

### Family Plan Information

**Complete this section ONLY if you have chosen the Family Plan.**

**Spouse:** Last Name First Name Initial Date of Birth DD/MM/YYYY

**Family Plan Beneficiary:** The beneficiary of all dependents' loss of life benefits will be the Applicant.

## Section 5: Personal Information

**IMPORTANT:** Any reference to testing, tests, test results or investigations in this section excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Applicant's Name Applicant's Phone Number

Physician's Name Physician's Phone Number Date last seen DD/MM/YYYY

Reason and result of last consultation.

Tests, treatment or medication prescribed (if none, state "None"):

Height (include ft & in or cm): Weight (include lb or kg):

Has your weight changed by more than 10 lbs (4.5 kg) in the past 12 months? ☐ Yes ☐ No

If yes: ☐ Gained (include lb or kg): ☐ Lost (include lb or kg):

Reason for change:

**Please ensure all questions are answered and details provided. If you require additional space, please use a separate page, signed and dated.**

| | Applicant YES | NO |
|---|---|---|
| **Have you:** | | |
| 5.1 Ever applied for any insurance that was declined, modified or rated?<br>If yes, give details including date, name of company and reason: | ☐ | ☐ |
| 5.2 a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked?<br>If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked: | ☐ | ☐ |
| b) Within the past 2 years, been charged with or convicted of 2 or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving or failure to provide a breathalyzer sample)?<br>If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province/territory: | ☐ | ☐ |
| 5.3 Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s): | ☐ | ☐ |
| 5.4 Within the next 12 months:<br>a) Any expectation to travel outside Canada and the United States of America?<br>If yes, give details including where, when, why and for how long: | ☐ | ☐ |
| b) Any expectation to change your country of residence?<br>If yes, provide details, including where you intend to move, when you are moving, why you are moving and if your occupation is changing: | ☐ | ☐ |
| 5.5 Within the past 5 years:<br>a) Used any drugs other than for medical purposes; used marijuana; or have you been advised, treated or counselled for alcohol or drug abuse?<br>If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used: | ☐ | ☐ |
| b) Been convicted of a criminal offence or are you currently charged with one?<br>If yes, please provide details: | ☐ | ☐ |
| c) Declared, or are you currently contemplating personal or business bankruptcy?<br>If yes, provide details including date of discharge: | ☐ | ☐ |

## Section 6: Financial Information

6.1 **Please check as appropriate and attach financial document where indicated:**

- ☐ New General Practitioner – in first 2 years of graduating from a Residency Program – Disability amount from all sources of $7,500 or less. Proof of income not required.
- ☐ New Specialists – in first 2 years of graduating from a Residency Program – Disability amount from all sources of $11,000 or less. Proof of income not required.
- ☐ Fellows - Disability amount from all sources of $ 11,000 or less. Proof of income not required.
- ☐ Fee-for-Service Physician – over 2 years in practice and coverage of $5,000 per month from all sources (in force and applied for). Attach copy of last 2 years' income tax returns plus Statement of Professional or Business Activity. If incorporated, also attach the latest Corporate Financial Statement.
- ☐ Employed Physician (no ownership) – over 2 years in practice and coverage of $5,000 per month from all sources (in force and applied for). Attach copy of salary/employment letter or copy of last income tax return. (Ensure you provide details of any group coverage through your employer in Section 3.)

6.2 Your employment status: ☐ Employee (no ownership) ☐ Self-employed

6.3 Describe Occupation/Medical Specialty:

6.4 If self-employed, what is the organizational structure of your business?
☐ Sole proprietor ☐ Partnership ☐ Corporation If incorporated, give percentage of ownership: %

6.5 How long have you been self-employed? Since MM/YYYY

6.6 If self-employed less than two years, give details of previous employment history, if any:

6.7 How many hours do you work per week?

6.8 Do you have any part-time or other full-time jobs? ☐ Yes ☐ No
If yes, provide details:

6.9 Do you expect your income or employment situation to change within the next 12 months? ☐ Yes ☐ No
If yes, provide details:

### Complete the following only if applying for Disability Income Replacement Insurance Plan

6.10 What was your Net Annual Earned Income (after regular business expenses but before taxes)?
Last year: $ Two years ago: $

6.11 Is your net worth (assets minus liabilities other than personal use assets such as residence, automobile, jewelry) greater than $5,000,000? ☐ Yes ☐ No

6.12 Do you have any income which will become payable or continue should you become disabled? ☐ Yes ☐ No

6.13 If yes, indicate annual amount and source:

6.14 Is your unearned or investment income for last year greater than $30,000 or 15% of your insurable Net Annual Earned Income? ☐ Yes ☐ No

6.15 Are you eligible for employment insurance? ☐ Yes ☐ No

### Complete the following only if applying for Office Overhead Expense Insurance Plan

6.16 What are your total monthly business expenses? (Calculate using totals below) $

| | | | |
|---|---|---|---|
| Accounting services: | $ | Business taxes, interest on loans: | $ |
| Rental costs: | $ | Insurance: | $ |
| Association/membership dues: | $ | Rent/mortgage interest: | $ |
| Salaries/benefits for employed family members: | $ | Salaries/benefits for non-family employees: | $ |
| Telephone, telephone answering service, etc.: | $ | Utlilities: | $ |
| Other normal and fixed customary expenses: | $ | **Total Monthly Expenses:** | $ |

6.17 Do you share office expenses? ☐ Yes ☐ No
If yes, what is your percentage share? %

**Your total benefits cannot exceed the amount of eligible incurred expenses at time of claim (from all sources).**

## Section 7: Payment Information

Doctors Manitoba will be collecting your payment information separately for purposes of premium payments.

## Section 8: Additional 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 501**
**Toronto, Ontario M5G 1R7**
**Telephone: (416) 597-0590**
**Fax: (416) 597-1193**
**Email: canada_disclosure@mib.com**

## 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, date of birth or driver's licence
- A personal investigation, financial information, credit bureau report and/or a consumer report from any organization, 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
- 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

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 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 abovementioned 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/territorial 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 centre 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 North**
**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.

A copy of our privacy principles and practices is available at manulife.ca.

## Declaration and Authorization – Please read carefully before signing.

I (the Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I declare that the statements contained in this application, including the health declaration originally attached hereto, are true and complete. I understand that this application, together with any other forms signed by me in connection with this application, forms the basis for any certificate or additional coverage issued hereunder. The person to be insured understands that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I understand that exclusions and limitations apply to the coverage applied for. Suicide within the first two years is a risk not covered. Relative to the insurance applied for, I, the person to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, 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 or the health of any member of my family to be insured pursuant to this application 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, its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional, and that if I wish to discontinue such use, I may write to Manulife at the address shown on this document. A photocopy or faxed copy of this authorization shall be as valid as the original.

I acknowledge receipt of and confirm my agreement with the Declaration and Authorization, Information about MIB, Inc. and Personal Information Statement.

I (the Applicant) hereby designate the individual(s) named as beneficiary(ies) to receive the proceeds payable upon my death.

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.

I acknowledge that the insurer may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be made at no expense to me. I further acknowledge that results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law, and that based on my health information, Manulife may offer insurance on an alternative basis or may decline to offer coverage.

I acknowledge that coverage will take effect on the date the properly completed application (including my properly completed health declaration) and the first premium are received by Manulife, subject to the approval of the Company's underwriters. If I am approved, I will receive a certificate specifying the coverage provided and outlining the main policy provisions. If I am not insurable, a full refund of the premiums will be made.

By providing your email address herein, you consent to us providing information or documents to you in respect of this application or policy, as applicable, in electronic form.

Signature of Applicant Dated DD/MM/YYYY Signed at City, Province/Territory

Signature of Witness

## Advisor's report

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent;
- that you may receive commissions for the sale of life, accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

| Your Name (first, middle initial, last) | Advisor Code | Signature |
|---|---|---|
| | | |

For more information visit the website at **doctorsmanitoba.ca**
or call us toll-free at **1-888-322-4242**
20 Desjardins Drive, Winnipeg, Manitoba R3X 0E8

Manulife

Underwritten by **The Manufacturers Life Insurance Company (Manulife).**