APPLICATION FOR COVERAGE

Coverage detail

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

- Sections 1-2: To be completed by member. Retain a copy of all sections for your files.
- Sections 3-4: To be completed by the member/spouse, including the beneficiary designation. Retain a copy of all sections for your files.

Send to: **Doctors Manitoba**
20 Desjardins Drive
Winnipeg, MB R3X 0E8
Email: **insurance@doctorsmanitoba.ca**

1 Member and dependant details (completed by member)

Member information

Name of group policyholder (Employer)	Policy no.	Member no.
DOCTORS MANITOBA	**335330**	

Member last name	First name	Middle initial	Gender	Date of birth
			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY

Home mailing address Street	City	Province	Postal code

Email address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Mobile phone number	Alternate contact number / extension
XXX-XXX-XXXX	XXX-XXX-XXXX XXXX

NOTE: If you provide your mobile number, we may use it to communicate messages with you about this application.

Spouse information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse last name	First name	Middle initial	Gender	Date of birth
			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY

Home mailing address (if different from member) Street	City	Province	Postal code

Email address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Mobile phone number	Alternate contact number / extension
XXX-XXX-XXXX	XXX-XXX-XXXX XXXX

NOTE: If you provide your mobile number, we may use it to communicate messages with you about this application.

2 Reason for application (completed by member)

Do you currently have any Optional Life insurance under this group insurance plan? ☐ Yes ☐ No

If Optional, provide amount: $ _____

I apply for insurance under the Policy issued by The Canada Life Assurance Company to Doctors Manitoba, subject to the terms and provisions thereof. (Do not include any benefits already in force under this Plan.)

	Available in Units of $7,500	Coverage Required
☐ Term Life Insurance **Plan B**	No. of units _____ X 7,500	= $ _____
☐ Term Life Insurance **Plan B** (Spouse)	No. of units _____ X 7,500	= $ _____
☐ Term Life Insurance **Plan A** (Spouse and Child)	Spouse	= $ _____
	(Per) Child	= $ _____

▶ Life beneficiary designation (completed by member)

Member life beneficiary designation

First name	Last name	Relationship to plan member

Spouse life beneficiary designation

First name	Last name	Relationship to spouse

■ **Contingent beneficiary** - If the above beneficiary dies before me, the death benefit set out in the plan is to be paid to:

☐ My estate, or

Name of contingent beneficiary	Relationship to Plan member

■ **Trustee – recommended for any beneficiary under age 18, or any beneficiary who may not be able to give a valid discharge. Do not use this section if there is a written trust agreement.**

I appoint _____

Relationship to life to be insured _____

as trustee to receive, in trust, benefits under the Canada Life group policy referred to above. This appointment applies to benefits payable to anybeneficiary designated under this contract who, at the time benefits are payable, is a minor or lacks legal capacity to give a valid discharge according to the laws of the beneficiary's domicile. Payment of benefits to the trustee discharges Canada Life to the extent of the payment.

I authorize the trustee in his or her sole discretion to use the benefits for the education or maintenance of the beneficiary and to exercise any right of thebeneficiary under the group policy. The trustee may, in addition to the investments authorized for trustees, invest in any product of, or offered by, Canada Life or its affiliated financial institutions. The trust for any beneficiary will terminate, once that beneficiary is both of age of majority and has legal capacity to give a valid discharge, and I direct the trustee to deliver at that time to the beneficiary, the assets held in trust for that beneficiary. I or my personal representative may by writing appoint a new trustee to replace a former trustee.

☐ No trustee desired

Owner (if other than applicant)

First name	Last name	Relationship to applicant

Residence telephone number		Business Telephone Number

Address same as Applicant ☐ or

Address - Street/Apt No.	City/Town	Province/Territory	Postal code

▶ Plan member's signature

Signature	Date MMM/DD/YYYY

canada life™

EVIDENCE OF INSURABILITY

Medical & lifestyle questionnaire

3 Personal medical history and lifestyle information

Genetic Non-Discrimination Act

You should not tell us about any genetic test (that is, any analysis of DNA or RNA chromosomes) which you may have had done. However, you must tell us if you're having treatment for, or experiencing symptoms of a genetic condition. You will be asked to provide us full information about your family history, including all genetic conditions.

If you answer 'yes' to any of the health questions, Canada Life will require more information to assess your application. In this case, a representative of Canada Life will contact you to complete a health assessment.

MB = Member **SP** = Spouse

1. What is your **current** height and weight?
   We need an accurate current measure, not an estimate.

	Height	Weight
MB	_____ ☐ feet/inches ☐ m/cm	_____ ☐ pounds ☐ kg
SP	_____ ☐ feet/inches ☐ m/cm	_____ ☐ pounds ☐ kg

2. Have you **ever** been treated for, or had any known indication of:
   - Conditions or issues affecting your heart, blood, circulation, high blood pressure, high cholesterol, immune system such as HIV or AIDS, breathing such as tuberculosis, emphysema, COPD, sleep apnea or asthma (excluding non-smokers with mild/seasonal asthma), or any other lung or respiratory problems
   - Conditions, issues or injuries affecting your brain or nervous system, such as aneurysm, stroke, concussion, epilepsy, seizures, numbness, multiple sclerosis, ALS, Huntington's, Parkinson's
   - Conditions or issues affecting your esophagus, stomach, pancreas, liver, gall bladder or bile duct, intestine, colon, bladder (excluding resolved bladder infections), kidneys, prostate or reproductive system, such as Crohn's disease or colitis
   - Loss of speech, loss of sight, loss of hearing or any condition affecting your eyes or ears
     You do not need to tell us about ear tubes, vision corrected with eye glasses/contact lenses or minor infections which have completely resolved
   - Any form of cancer, tumor (benign or malignant), diabetes, abnormal blood sugar or sugar in the urine, hepatitis, or lupus
   - Any bone, joint, muscle or skin condition, such as arthritis, psoriasis, ankylosing spondylitis or back pain, that **ever** require(d) medication or treatment
     You do not need to tell us about a muscle or bone injury, or minor infection, from which you have completely recovered
   - Any conditions or issues affecting your behaviour or mental health, such as anorexia nervosa, bulimia, depression, bipolar disorder, self-harm, schizophrenia, stress, or anxiety, requiring medication, treatment or time off work/school

	Yes	No
MB	☐	☐
SP	☐	☐

3. Other than for a regularly scheduled physical or routine check-up, are you **currently** undergoing or awaiting any consultations or exams, or recommended, scheduled or pending tests or test results, treatment or procedures, including surgery, for any health issues, symptoms or conditions?
   Other than an uncomplicated pregnancy, vasectomy, dental surgery, cosmetic surgery or a muscle/joint or bone injury which you have fully recovered from, this includes (but is not limited to): biopsies, ECGs, x-rays, CT scans, MRIs, blood tests, ultrasounds, endoscopies, colonoscopies, pap tests, mammograms.

	Yes	No
MB	☐	☐
SP	☐	☐

4. Do any of your immediate biological family members (parents, siblings, children), suffer or have suffered from any of the following:
   - Alzheimer's Disease
   - Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
   - Cancer
   - Cardiomyopathy
   - Dementia
   - Diabetes
   - Heart Disease
   - Huntington's chorea
   - Motor Neuron disease
   - Multiple Sclerosis
   - Parkinson's Disease
   - Polycystic Kidney disease
   - Retinitis Pigmentosa
   - Stroke
   - and/or any other **hereditary** medical condition

	Yes	No
MB	☐	☐
SP	☐	☐

5. In the **past 12 months**, have you used any form of tobacco, nicotine products or nicotine substitute?
   This includes: cigarettes, e-cigarettes/vaporizers, cigarillos, pipe, cigars, chewing tobacco, nicotine patch and/or gum, hookah/shisha, or such products in any other form.

	Yes	No
MB	☐	☐
SP	☐	☐

6. In the **past 10 years**, have you used any drug(s) or narcotic(s) **(including cannabis)**, or had any issues with alcohol abuse including being advised to stop or reduce your consumption?

	Yes	No
MB	☐	☐
SP	☐	☐

7. In the **past 2 years**, have you engaged in any high-risk activities, or do you plan to do so in the **next 12 months**?
   Examples include: aviation (pilot or crew member), boxing, ballooning, bungee jumping, hang gliding, heli skiing/snowboarding, motorized racing (car, motorcycle, boat, snowmobile, etc.), rock/ice climbing, scuba diving, skydiving or other parachute jumping, or white water rafting.

	Yes	No
MB	☐	☐
SP	☐	☐

Notice about MIB inc.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Canada Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance or submit a claim for benefits to such a company, the bureau will upon request supply the company with the information it may have.

Canada Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau's information office at:

MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Tel 781-751-6000

Protecting your personal information

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship. *The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.*

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Authorization and declarations

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Canada Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Canada Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Canada Life to communicate with me about this application, with electronic messages, using either the mobile number or the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Canada Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- I have retained a copy of this application;
- If applying for coverage for dependents, I am authorized to act on their behalf;
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the effective date of any coverage approved by Canada Life must be reported to Canada Life. I understand that if I fail to do so, any coverage granted may be void.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Canada Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Employee signature _____ Date signed _____
MMM/DD/YYYY

Spouse signature _____ Date signed _____
MMM/DD/YYYY

Questions?

Email: groupmed@canadalife.com
Telecommunications Relay Service: 1.800.855.0511
(available for the hearing impaired)

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Coverage detail

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

Plan administrator instructions:

- Sections 1-2: Review Section #2 to ensure the benefit(s) requested is/are accurate and then provide your authorization as well as your name and contact information in Section #1. Submit the Coverage Detail page with the attached envelope to Canada Life.
- Plan administrator to send the form directly to Canada Life via mail/email.

4 Plan administrator information

Name of group policyholder (Employer)	Policy no.
DOCTORS MANITOBA	**335330**

Plan administrator's name	Plan administrator's Phone No. XXX-XXX-XXXX	Plan administrator's email address

Plan administrator's authorization	Date authorized MMM/DD/YYYY
☐ I hereby certify that the information on this Coverage Detail form is accurate.	