Manulife

ALBERTA MEDICAL ASSOCIATION

Application for Insurance

For the members of the Alberta Medical Association and/or their spouse

1. Member Information

In this application, *we*, *us* and *our* refer to the Manufacturers Life Insurance Company. *You* and *your* refer to the person to be insured.

You will be billed personally unless otherwise requested below

*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.

AMA# Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐

Last Name: First Name: Middle Initial:

Former Maiden Name (if applicable): Date of Birth: (dd/mm/yyyy):

Province of birth: Country of birth:

Address (street number or name): Apartment or Suite:

City: Province: Postal Code:

Email Address (optional):

Telephone (Residence): Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

☐ Alternative billing information (if different from above):

1.2 Business Information

Name of clinic/hospital:

Business address (street number or name): Apartment or suite:

City: Province: Postal Code:

Telephone (Business): Fax:

1.3 Contact Preference

Send correspondence to: ☐ Residence address ☐ Business address

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)

1.4 Spouse Information (if applying for insurance)

Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐

Last Name: First Name: Middle Initial:

Former Maiden Name (if applicable): Date of Birth (dd/mm/yyyy):

Province of birth: Country of birth:

☐ Same address as member, or

Address: Apartment or Suite:

City: Province: Postal Code:

1.4 Spouse Information (if applying for insurance continued)

*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.

Email Address:

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

Telephone (Residence): Telephone (Business):

Telephone (Cell):

Occupation Amount of annual income ($)

1.5 Spouse Contact Preference

Send correspondence to: ☐ Residence address ☐ Business address

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)

2.1 Member Life Insurance

Minimum $50,000, Maximum $5,000,000, in units of $50,000

If no beneficiary is designated, benefits will be payable to the Estate.

If you wish to name multiple beneficiaries, or your beneficiary is a minor, contact adium@albertadoctors.org for a beneficiary form.

Amount of new insurance applied for at this time ($)

Waiver of Premium rider ☐ Yes Future Insurance Option rider ☐ Yes

Name of Primary Beneficiary:

Relationship to proposed insured:

Name of Secondary Beneficiary:

Relationship to proposed insured:

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for.

2.2 Spouse Life Insurance

Minimum $50,000 , Maximum $5,000,000 in units of $50,000

If no beneficiary is designated, benefits will be payable to the Estate.

If you wish to name multiple beneficiaries, or your beneficiary is a minor, contact adium@albertadoctors.org for a beneficiary form.

Amount of new insurance applied for at this time ($)

Waiver of Premium rider ☐ Yes Future Insurance Option rider ☐ Yes

Name of Primary Beneficiary:

Relationship to proposed insured:

Name of Secondary Beneficiary:

Relationship to proposed insured:

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for.

2.3 Member Disability Insurance

Minimum $500, Maximum $25,000, in units of $100

Amount of new insurance applied for at this time ($)

Elimination periods:

30 days 60 days 90 days 120 days

Indicate any optional riders applied for:

☐ Cost of Living Adjustment
☐ Guaranteed Insurability Benefit
☐ Own Occupation
☐ Lifetime Accident Total Disability
☐ Retirement Protection
- ☐ $500 monthly contribution benefit
- ☐ $1,000 monthly contribution benefit

2.4 Member Professional Overhead Expense (POE) Insurance

Minimum $500, Maximum $30,000, in units of $100

Amount of new insurance applied for at this time ($)

Elimination periods:

14 days (up to $8,000) ________ 30 days (up to $30,000) ________

Guaranteed Insurability Benefit rider: ☐ Yes

2.5 Critical Illness Insurance

Member Critical Illness insurance

Minimum $50,000, Maximum $1,000,000, in units of $10,000

Amount of new insurance applied for at this time ($)

________ Waiver of Premium rider: ☐ Yes

Spouse Critical Illness insurance

Minimum $50,000, Maximum $1,000,000, in units of $10,000

Amount of new insurance applied for at this time ($)

________ Waiver of Premium rider: ☐ Yes

Child information if applying for Dependent Child Critical Illness insurance

Amount of new insurance applied for at this time

☐ $5,000 ☐ $10,000 ☐ $ 15,000 ☐ $20,000

Child's last name	Child's first name	Date of birth (dd/mm/yyyy)	
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

3. Insurance Information

Note: Do not cancel any existing coverage until the coverage you have applied for has been approved.

Do you have any pending or existing disability, professional overhead expense, life or critical illness insurance other than AMA or PARA group insurance plans or creditor insurance for mortgage or loan amounts?

☐ Yes ☐ No If yes, provide details below

Name of applicant	Amount of benefit ($)	Type of coverage	Insuring Company
Date of issue (mm/ yyyy)	**Benefit period**	**Taxable**	**Will this insurance be discontinued if this coverage you have applied for is issued?**
		☐ Yes ☐ No	☐ Yes ☐ No

Name of applicant	Amount of benefit ($)	Type of coverage	Insuring Company
Date of issue (mm/ yyyy)	**Benefit period**	**Taxable**	**Will this insurance be discontinued if this coverage you have applied for is issued?**
		☐ Yes ☐ No	☐ Yes ☐ No

Name of applicant	Amount of benefit ($)	Type of coverage	Insuring Company
Date of issue (mm/ yyyy)	**Benefit period**	**Taxable**	**Will this insurance be discontinued if this coverage you have applied for is issued?**
		☐ Yes ☐ No	☐ Yes ☐ No

4. Financial Information

Complete this section if you are a member and applying for Disability or Professional Overhead Expense Insurance.

a) Please check as appropriate and attach financial documentation accordingly.

☐ Coverage applied for and in force from all sources is $10,000/month or less—proof of income is not required.

☐ Coverage applied for and in force from all sources is $10,001/month or over—a copy of last two years' personal tax returns is required, and if incorporated, a copy of your latest Corporate Financial Statement is also required. (If Employed Physician with no ownership, a copy of salary or employment letter or copy of your last tax return is required). Ensure you provide details of any group coverage through your employer under Other Info).

If in first two years of practice in Canada:

☐ General Practitioners can apply for up to $7,500/month (all sources)—proof of income not required.

☐ Specialists and Fellows can apply for up to $11,000/month (all sources)—proof of income not required.

b) Your employment status: ☐ Employee ☐ Self-employed

c) i. Medical specialty: _____

ii. Date initial medical practice commenced in Canada (if within the last 2 years) (dd/mm/yyyy): _____

d) i. If self-employed, what is the organizational structure of your business?

☐ Sole proprietor ☐ Partnership ☐ Corporation If incorporated, give percentage of ownership _____ %

ii. How long have you been self-employed? Since _____

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

_____

e) i. How many hours do you work per week? _____

If less than 25 hours per week, please explain:

_____

ii. How many weeks do you work per year? _____

If less than 46 weeks per year, please explain:

_____

f) Do you expect your income or employment situation to change within the next 12 months? ☐ Yes ☐ No

If yes, provide details: _____

g) What was your net annual earned income (after regular business expenses but before taxes)?

Last year: $ _____ Two years ago: $ _____

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

If yes, provide details: _____

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

If yes, indicate annual amount and source: $ _____

j) Is your unearned or investment income for last year greater than $30,000 or 15% of your insurable net annual earned income? ☐ Yes ☐ No

k) Are you eligible for employment insurance? ☐ Yes ☐ No

l) Have you ever declared or are you contemplating bankruptcy? ☐ Yes ☐ No

If yes, date of discharge (dd/mm/yyyy) _____

5. Income Documentation for Disability Insurance

If you are applying for Disability insurance, financial documents are required to confirm your income (unless you are in residency or have commenced your initial medical practice in Canada in the last 2 years).

The following income documentation will be required depending on your business structure.

Employed (salaried)

- Most current T4 or,
- Income tax return - t1 (pages 1-4)

Sole Proprietor or Partnership

- Income tax return - T1 (pages 1-4) and,
- Statement of Business or Professional Activities (T2125)

Incorporated

- Most current T4 or,
- Personal income tax return - T1 (pages 1-4) and,
- Business Financial Statements of the Corporation

6. Expense Documentation for Professional Overhead Expense Insurance

If you are applying for Professional Overhead Expense insurance that exceeds a total of $10,000 per month, financial documents are required to confirm your expenses.

The following income documentation will be required depending on your business structure.

Sole Proprietor or Partnership

- Statement of Business or Professional Activities (T2125)

Incorporated

- Business Financial Statements of the Corporation

7. Accountant Information

☐ I am enclosing the required documentation, or

☐ Contact my accountant to obtain the required income documentation

Accountant Last Name: First Name:

Company Name:

Email Address:

Telephone (Residence): Telephone (Cell):

8. Declaration and Authorization

I /We (the Member/Spouse) 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.

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/We hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

I/We acknowledge my/our receipt of and agreement with the Notice on Privacy and Confidentiality and Notice of Exchange on Information .

If my/our application is approved, I/we will receive a certificate of insurance specifying the coverage provided and the main policy provisions.

Signed at (city or town): Signed at (province):

Name of member: Name of spouse:

Signature of member: X Date (dd/mm/yyyy):

Signature of spouse: X Date (dd/mm/yyyy):

Note: Your completed application must be submitted within one month of the date you sign.

Return your completed application to:
ADIUM Insurance Services Inc CMA Alberta House
12230 106 Avenue NW Edmonton AB T5N 3Z1
Fax: 780-488-7558 or 1-877-302-3486
Email: adium@albertadoctors.org

Transmitting your personal information electronically is not a secure method of electronic communication and has several risks associated with it. We encourage you to use the AMA Member Dashboard (http:www.albertadoctors.org/dashboard) for the exchange of personal information.

For general information:
Call Toll-free: 1-888-492-3486
Website: www.albertadoctors.org.

9. Premium Payments

Monthly or Annual pre-authorized debit (PAD)
Indicate payment frequency:

- ☐ Monthly (interest free)
- ☐ Annual (full payment for balance of calendar year and annually the first week of January thereafter)
- ☐ Please add payments to my existing pre-authorized debit plan

Complete this section if you're making payments by pre-authorized debit
Attach a void cheque from the account you wish to be debited, OR complete this section

Account holder last name: | Account holder first name:

Address of your Canadian bank or financial institution (street number and name)

Name of Canadian bank or financial institution: | Transit number:

Institution number: | Account number:

Joint Accounts: Is this a joint account requiring more than one signature? ☐ Yes ☐ No

If more than one signature is required on withdrawals issued from the account, both account holders must sign this authorization.

Signature of account holder: X | Date (dd/mm/yyyy):

Signature of account holder: X | Date (dd/mm/yyyy):

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing priviledges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withrdawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

10. Premium Authorization

I/We authorize the Alberta Medical Association (AMA) to collect the monthly premium (including applicable provincial tax) for this insurance through Pre-Authorized Debit (PAD). I/We acknowledge that my/our financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. I/We acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. I/We agree to waive the requirement that the AMA notify me/us of any payments after the first payment whether the amount of the monthly premium is changed or not. I/We understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if the AMA is unable to make a withdrawal from my/our account.

This authorization is to remain in effect until the AMA has received written notification from myself/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. I/We may obtain a sample PAD cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca.

The AMA may not assign this authorization to another company or person to permit them to debit my/our account for these payments (for example where there has been a change in control of the company) without providing at least 10 days' prior written notice to me/us.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca.

ADIUM Insurance Services Inc.
CMA Alberta House
12230 106 Avenue NW Edmonton, AB T5N 3Z1 adium@albertadoctors.org

11. 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 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

12. Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract , the insured and the parent or guardian of any child named as insured who is under the legal age for 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
- 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 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
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- 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.

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 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, 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, 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.

Underwritten by The Manufacturers Life Insurance Company (Manulife).