Manulife

ALBERTA MEDICAL ASSOCIATION

PARA Professional Association of Resident Physicians of Alberta

Conversion application for PARA disability and life insurance

1. General 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.

*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.

Member AMA#

Last Name: | First Name: | Middle Initial:

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

Residence Address: | Apartment or Suite:

City: | Province: | Postal Code:

Email Address:

Telephone (preferred contact number): | Telephone (Cell):

May we correspond with you via email so that we may contact you for the administration of this application? ☐ Yes ☐ No

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

Date residency program completed (dd-mm-yyyy):

Indicate date you will be commencing

☐ Full time medical practice (minimum25 hours per week) Date (dd-mm-yyyy):

☐ Fellowship training Date (dd-mm-yyyy):

☐ In Alberta

Is your fellowship ministry funded? ☐ Yes ☐ No

☐ Outside Alberta

Expected completion date Date (dd-mm-yyyy):

2. Coverage applied for

I hereby designate the named

individual as beneficiary on this application 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.

If you wish to name a secondary beneficiary or multiple beneficiaries, contact **adium@albertadoctors.org** for a beneficiary form.

I wish to apply for conversion of my PARA insurance to the AMA group plan as indicated:

Life Insurance coverage ☐ Yes ☐ No If **yes**, beneficiary for Life Insurance coverage

Beneficiary last name: | Beneficiary first name:

Relationship to the proposed insured:

Trustee (if beneficiary is under the age of 18)

3. Coverage applied for (continued)

Disability Insurance coverage ☐ Yes ☐ No

Indicate your final postgraduate pay level

☐ PGY 2 ☐ PGY 3 ☐ PGY 4 ☐ PGY 5 ☐ PGY 6 ☐ PGY 7 ☐ PGY 8

You are automatically issued the Guaranteed Insurability Benefit (GIB) rider with your conversion. Would you like to exercise the GIB option to increase your coverage using the completion of residency option?

☐ Yes ☐ No If **yes**, complete the GIB application for residents.

You are automatically issued the Cost of Living Adjustment (COLA) rider with your conversion. Would you like to add the COLA rider to any existing AMA disability insurance coverage you carry now?

☐ Yes ☐ No ☐ N/A

Do you wish to purchase the **Own Occupation rider**? ☐ Yes ☐ No

If yes, do you wish to add the Own Occupation rider to any existing AMA disability insurance? ☐ Yes ☐ No ☐ N/A

Do you wish to purchase the **Retirement Protection rider**? ☐ Yes ☐ No

Do you wish to purchase the **Lifetime Accident Total Disability rider**? ☐ Yes ☐ No

If yes, do you wish to add the Lifetime Accident Total Disability rider to any existing AMA disability insurance? ☐ Yes ☐ No ☐ N/A

4. 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 first name: | Account holder last 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: | Date (dd/mm/yyyy):

Signature of account holder: | 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.

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 any insurance issued pursuant to this application voidable at the instance of the insurer. 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 the insurance coverage, 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 acknowledge my receipt of and agreement with the Personal Information Statement.

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

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

Return your completed application to:
ADIUM Insurance Services Inc
Alberta Medical Association
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 use the AMA Member Dashboard (http:www.albertadoctors.org/dashboard) for the exchange of personal information.

For general information, you may call us
toll-free at **1-888-492-3486** or
visit our website at **www.albertadoctors.org**.

6. 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).

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