# Manulife

### APPLICATION To Convert Basic Life Insurance and/or Family Life Insurance to Term 100 Life Insurance

For assistance in filling out this application, call: **CDSPI Advisory Services Inc.** 1.800.561.9401 or 416.296.9401, Email: insurance@cdspi.com

Please complete all pertinent questions to avoid processing delays and return to: CDSPI,

155 Lesmill Road, Toronto, Ontario M3B 2T8. Fax: 1.866.337.3389 or 416.296.8920

Accessible formats and communication supports are available upon request. Visit cdspi.com/accessibility for more information.

# **INDIVIDUAL INFORMATION**

| Section 1 | Applicant Information |
|-----------|-----------------------|
|           |                       |

Dental Specialty: \_

| 1. | Name ( <i>please print</i> ):  | 5  |  |  |  |  |  |  |
|----|--|--|--|--|--|--|--|--|
|    | Check one: $\Box$ Dr. $\Box$ Mr. $\Box$ Mrs. $\Box$ Miss $\Box$ Ms. $\Box$ Corporation | Email address ( <i>please include to expedite the application process</i> )<br><b>6. A.</b> Account Number, if known:  |  |  |  |  |  |  |
|    |  |  |  |  |  |  |  |  |
|    | Last (or name of partnership or corporation) First Middle or Middle Initial            |  |  |  |  |  |  |  |
| 2. | Individuals only: 🗆 Male 🗆 Female  | □ Same as current  |  |  |  |  |  |  |
|    |  | □ Annually   |  |  |  |  |  |  |
| 3. | Mailing Address:   | Quarterly  |  |  |  |  |  |  |
|    | Check one: 🗆 Home 🗆 Business   | □ Monthly*   |  |  |  |  |  |  |
|    |  | <ul> <li>Pre-authorized Chequing*</li> <li>Automatic VISA/MasterCard*</li> </ul>   |  |  |  |  |  |  |
|    | Street and Number Suite No.  | * To pay monthly, quarterly or annually under this option, you must  |  |  |  |  |  |  |
|    | City/Town Province Postal Code   | complete and send in a pre-authorized payment plan form. To obtain this form, visit www.cdspi.com/pac-insurance.   |  |  |  |  |  |  |
| 4. |  | <u>Note:</u> Processing charges of 3.98% and 3.73% apply to monthly and  |  |  |  |  |  |  |
|    | Business Telephone Home Telephone  | quarterly payments respectively.   |  |  |  |  |  |  |
|    |  | <b>7.</b> Language Preference:   English  French   |  |  |  |  |  |  |
|    | Mobile Telephone Fax   |  |  |  |  |  |  |  |
| S  | ection 2 Person To Be Insured  |  |  |  |  |  |  |  |
|    | <u>e:</u> Please complete even if the Person To Be Insured is the same as              | <b>B.</b> Dental Student   |  |  |  |  |  |  |
|    | applicant.   |  |  |  |  |  |  |  |
| 1. | Name (please print):   | Name of University or Dental Faculty:  |  |  |  |  |  |  |
|    | Check one: $\Box$ Dr. $\Box$ Mr. $\Box$ Mrs. $\Box$ Miss $\Box$ Ms.                    | <b>C.</b> Don-Dependent Adult Child of Eligible Dental Association<br>Member Dentist   |  |  |  |  |  |  |
|    | Last First Middle or Middle Initial  | Name of Dentist:   |  |  |  |  |  |  |
| •  |  |  |  |  |  |  |  |  |
| 2. | Male     Female  | <b>D.</b>  |  |  |  |  |  |  |
| 3. | $\Box$ Smoker $\Box$ Non-Smoker <sup>†</sup>   |  |  |  |  |  |  |  |
| 4. | Date of Birth:   | Name of Dentist:   |  |  |  |  |  |  |
|    | Day Month Year   | E. 🗆 Employee of Dental Association  |  |  |  |  |  |  |
| 5. | STATUS (check one):  | Name of Association:   |  |  |  |  |  |  |
|    | $\square$ Dentist  |  |  |  |  |  |  |  |
|    | Member of Provincial/Territorial Dental Association*                                   | F.   Spouse of Eligible Dental Association Member Dentist  |  |  |  |  |  |  |
|    | □ Member of CDA  | Name of Dentist:   |  |  |  |  |  |  |
|    | * Excluding the ACDQ in Quebec.  | <b>G.</b> 🗆 Other (please specify):  |  |  |  |  |  |  |
|    | Date of Graduation:  |  |  |  |  |  |  |  |
|    | Day Month Year   | 6. Occupation (if not a dentist or dental student):  |  |  |  |  |  |  |
|    | Name of University or Dental Faculty:  | <sup>†</sup> <u>Note:</u> You are considered a non-smoker if you have not used any form of tobacco or tobacco cessation products in the 12 months prior to signing this application. |  |  |  |  |  |  |



Plan underwritten by The Manufacturers Life Insurance Company.

### COVERAGE APPLIED FOR

### Section 3 Coverage Being Converted

You may convert up to the amount of Basic Life or Family Life coverage you have in force, but not beyond the plan maximum shown in Question 3.

1. Are you now disabled and on claim or satisfying an elimination period?  $\Box$  Yes  $\ \Box$  No

If "Yes", you are not eligible to convert your coverage at this time. Please contact CDSPI Advisory Services Inc. for more information.

**2.** Insurance coverage to be converted to Term 100 Life Insurance (*check one*):

□ Basic Life Insurance

□ Spouse Family Life Insurance

□ Adult Child Family Life Insurance

 $\Box$  Spouse of Adult Child Family Life Insurance

**3.** Amount of coverage to be converted to Term 100 Life Insurance (Minimum: \$50,000; Plan Maximum: \$1 million, including existing coverage)

Coverage Amount: \$ \_\_\_\_\_

AND

Policy Number(s):

OR

(check if desired) 
All Policies

#### Section 4 Beneficiaries

The beneficiary for your converted coverage will be the beneficiary on your existing coverage (and your contingent beneficiary). To change the beneficiary or contingent beneficiary, please contact CDSPI Advisory Services Inc. to obtain a Beneficiary Designation form. Your right to alter the interest of any beneficiary or contingent beneficiary is subject to any applicable law. **4.** Waiver of Premium Option

If your coverage to be converted includes the Waiver of Premium Option, do you wish to continue that option on your Term 100 coverage?  $\Box$  Yes  $\Box$  No

# DECLARATION AND AUTHORIZATION

#### Section 5 To Be Read, Signed and Dated By the Applicant (and Person To Be Insured if Other than the Applicant)

If this application is approved, the applicant will receive a certificate booklet containing a detailed description of coverage and limitations.

I/We apply to The Manufacturers Life Insurance Company (Manulife) for insurance indicated above under the group policy issued in connection with CDSPI. I/We, the undersigned, declare that the statements contained in this application are true and complete and, together with any other forms or documents signed or provided by me/us in connection with this application, form the basis for any Certificate of Insurance issued pursuant to this application. I/We understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. Suicide within two years of the effective date (or last reinstatement date of the coverage being converted) is a risk not covered. I/We understand that insurance will take effect on the date the properly completed application is approved by Manulife, subject to payment of the first premium within 30 days of issuance of a premium invoice. I/We understand that the insurance on a person who is disabled and who is satisfying the waiting period to have premiums waived, or for whom premiums are being waived, is not eligible for conversion of coverage.

If the applicant is other than myself, I (the Person To Be Insured) consent to the issuance of insurance on my life.

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

A photocopy or facsimile of this authorization shall be as valid as the original.

<u>NOTE:</u> Eligibility for coverage or increased coverage is limited to Canadian residents who are members of the CDA or a participating provincial or territorial dental association (in Quebec, only CDA members are eligible) and employees of participating dental associations or organizations.

| Signature of Person To Be Insured (if other than the Applicant) | Date: Day      | Month | Year | Signed at:<br>City/Town | Province |
|---|----------------|-------|------|-------------------------|----------|
| Signature of Applicant  | Date: L<br>Day | Month | Year | Signed at:<br>City/Town | Province |

#### **Additional Consents**

The undersigned irrevocable beneficiary and/or assignee (if applicable) consent(s) to the conversion of the coverage specified in this application.

| Signature of Irrevocable Beneficiary (if any) | Date: L<br>Day | Month | Year | Signed at:<br>City/Town | Province |
|---|----------------|-------|------|-------------------------|----------|
| Signature of Assignee (if any)                | Date: L<br>Day | Month | Year | Signed at:<br>City/Town | Province |

## 🔟 Manulife

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#### NOTICE ON PRIVACY AND CONFIDENTIALITY - Must be detached, read and retained by the Person To Be Insured

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information:

Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside of Canada, and subject to the laws of those foreign jurisdictions. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.

Access to information which you provide to CDSPI or CDSPI Advisory Services Inc. or which CDSPI obtains in its capacity as the administrator of the Master Agreement and/or group policy will be restricted to those employees, mandataries, administrators or agents of CDSPI or CDSPI Advisory Services Inc. who are responsible for the marketing and administration of services and the facilitation of claims under the Master Agreement and/or group policy, and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at CDSPI or CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

#### Plan underwritten by The Manufacturers Life Insurance Company.

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