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CDSPI ADVICE. INSURANCE. INVESTMENTS.

APPLICATION

For Additional Insurance Under the Future Insurance Guarantee (FIG) Option For DisabilityGuard™ Insurance

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416.296.9401, E-mail: insurance@cdspi.com
Please complete all pertinent questions to avoid processing delays and return to:
CDSPI, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4 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.

Application must be signed and submitted within 60 days of the birthday of the Person To Be Insured. The DisabilityGuard™ FIG Option may be exercised up to and including within 60 days of the Person To Be Insured's 55th birthday, subject to plan and FIG Option maximums.

*Any Future Insurance Guarantee increase approved will be issued **on the same basis** as the contract to which the Future Insurance Guarantee Option is attached.*

Section 1 Applicant Information

1. Name (*please print*):
Check one: ☐ Dr. ☐ Corporation†

Last First Middle or Middle Initial
(*or name of partnership or corporation*)

2. Individuals only: ☐ Male ☐ Female

3. Mailing Address: Check one: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

4.
Business Telephone Home Telephone Mobile Telephone Fax

5.
E-mail address (*please include to expedite the application process*)

6. Account Number, if known: |_|_|_|_|_|

Note: Your billing frequency will be the same as with your current coverage. If you wish to change your billing frequency, contact CDSPI.

7. Language Preference: ☐ English ☐ French

† **Note:** A Corporation is not normally the applicant for DisabilityGuard™ coverage due to tax implications. Contact CDSPI Advisory Services Inc. for further details.

Section 2 Person To Be Insured

Note: Please complete even if the Person To Be Insured is the same as the applicant.

1. Name (*please print*):

☐ Dr.
Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. Date of Birth: |_|_|_|_|_|_|_|_|
D D M M Y Y Y Y

Please return all pages of this application.

Section 3 Future Insurance Guarantee (FIG) Option information

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

If "Yes", please provide full details._____

_____

_____

2. A. Do you currently have in force or have you concurrently applied for any sickness or accident coverage (including disability coverage through your employer) or Retirement Protection coverage, provided by Individual or Group Policies, or Employment Contracts/Partnership Agreements, other than through CDSPI?

☐ Yes ☐ No If "Yes", please complete table below.

Insuring Company or Plan	Monthly Benefit ($)	Type of Coverage	Elimination Period	Benefit Period (e.g. 5 years, to age 65, etc.)	Taxable Benefit?
					☐ Yes ☐ No
					☐ Yes ☐ No

B. Will any disability insurance be discontinued if this coverage is issued?

☐ Yes ☐ No If "Yes", please complete the lines below.

Company _____

Amount ($) _____ Type of Coverage _____

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. In Quebec, a replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated. If the change of coverage described above does not occur, benefits may not be payable under the coverage exercised in this application.

C. Amount of additional FIG Option exercised* at this time (do not include existing coverages) in increments of $100:

30-Day Elimination Period** $ _____ ☐ Step Premium ☐ Level Premium

60-Day Elimination Period** $ _____ ☐ Step Premium ☐ Level Premium

90-Day Elimination Period** $ _____ ☐ Step Premium ☐ Level Premium

120-Day Elimination Period** $ _____ ☐ Step Premium ☐ Level Premium

* You are eligible to apply for up to 25% of the amount of your FIG Option DisabilityGuard™ coverage (rounded to the next higher $100). Total DisabilityGuard™ insurance coverage (in force and applied for) must not exceed the current maximum. You must qualify for increased coverage under the Income Ratio Guide at the time you exercise this option.

** Unless you select a longer Elimination Period, the Elimination Period(s) that currently apply to your FIG Option DisabilityGuard™ coverage will be applied in the same proportions to your new coverage.

The Cost of Living Adjustment Option will be included if you currently have this option.

Please return all pages of this application.

Section 4 Financial Information

1. Are you currently actively engaged in the Practice of Dentistry? ☐ Yes ☐ No

2. Annual Earned Income:

	Current Year to Date	Actual Last Year End	Year End – Two Years Prior
A. Your gross earned income (from all sources) including salary, fees, commissions and bonuses:	$	$	$
B. Less annual total of all your business expenses:	$	$	$
C. Net annual earned income after expenses and before taxes:	$	$	$

D. Date of practice fiscal year end: |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

E. Does your unearned income (investments, interest, pension, etc.) exceed 15% of your total earned income? ☐ Yes ☐ No

If "Yes", please provide the amount of your unearned income for:

Current Year to Date _____ Prior Year _____

Source(s) _____

PROOF OF INCOME: — applicable to DisabilityGuard™ insurance

If your total* coverage from all sources will exceed $4,000/month, please provide a copy of your last personal income tax return (a Notice of Assessment is not acceptable). If incorporated, also provide a copy of your last Corporate Financial Statement (all pages). If you are purchasing an existing practice, also provide a copy of the last Financial Statement (all pages) from the practice you are purchasing.

Note:

- If you are a dental specialist in your first 2 years of practice after graduating from a specialty program, no proof of income is required for up to $6,000/month total from all sources* for disability coverage.
- If you are exercising $500/month (or less) of additional DisabilityGuard™ coverage under the Future Insurance Guarantee (FIG) Option, the financial assessment is based on declared annual earned income on this application. However, proof of income will be required at every 3rd occurence of a FIG increase.

* Total all sources = All existing and applied for coverage with all companies.

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 or those of our administrator or agent. 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.

CDSPI and CDSPI Advisory Services Inc. collect, use and disclose your personal information on this application for purposes that include: determining your eligibility for our plans; administering and providing insurance and financial services to you; underwriting; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; marketing and to advise you of other related products and services. We limit access to your personal information in our files to our employees, authorized agents and third-party service providers, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You may request to review the personal information your file contains and make corrections by sending a written request to: CDSPI, Attn: The Chief Privacy Officer, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4. To find out more about our privacy practices, visit www.cdspi.com/privacy.

Plan underwritten by The Manufacturers Life Insurance Company.

DECLARATION AND AUTHORIZATION

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

I apply to The Manufacturers Life Insurance Company (Manulife) for the insurance indicated above under the group policies issued in connection with the Canadian Dentists' Insurance Program.

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 policy or Certificate of Insurance or coverage issued. I/We understand that any material misrepresentation shall render the insurance voidable at the instance of the insurer. I/We understand that any insurance issued 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, and subject to the Person To Be Insured being actively at work on that date.

If the applicant is other than myself, I (the Person To Be Insured) consent to the issuance of insurance for my well-being.

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.

Note: Eligibility for coverage or increased coverage is limited to Canadian citizens or permanent residents of Canada who are members of the CDA or participating provincial or territorial dental associations (in Quebec, only CDA members are eligible).

_____ Date: |_|_|_|_|_|_|_|_| Signed at: _____

Signature of Person To Be Insured (if other than the Applicant) — D D M M Y Y Y Y — City / Town — Province / Territory

_____ Date: |_|_|_|_|_|_|_|_| Signed at: _____

Signature of Applicant — D D M M Y Y Y Y — City / Town — Province / Territory

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