Manulife

CDSPI ADVICE. INSURANCE. INVESTMENTS.

APPLICATION

For Additional Insurance Under the Future Insurance Guarantee (FIG) Option– **Basic Life, DisabilityGuard™ and/or Office Overhead Expense 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, 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.

Important Note: When applying for increased coverage under the FIG Option on **Basic Life or Overhead Expense Insurance**, the application must be signed and submitted within 60 days of the date you attain 25, 30, 35, 40, 45 or 50 years of age, or the date you are married, or the date that a common-law relationship has existed for 24 months, or the date of birth or legal adoption of a child.
Note: If you are on maternity or parental leave, you may have an extended time period to exercise the FIG Option. Contact CDSPI Advisory Services Inc. for details. When exercising the FIG Option on **DisabilityGuard™ Insurance**, the 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. Mailing Address: Check one: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

3.
Business Telephone Home Telephone Mobile Telephone Fax

4.
Email address (*please include to expedite the application process*)

5. 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.

6. 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: |_|_|_|_|_|_|_|_|
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Please return <u>all</u> pages of this application.

Section 3 Future Insurance Guarantee Option information

1. Declaration of eligibility: *(check appropriate box)*

a) I am eligible to exercise the FIG Option under Basic Life and/or Office Overhead Expense insurance without medical evidence of insurability for the following reason (within 60 days):

☐ Attainment of age 25, 30, 35, 40, 45 or 50

☐ Marriage | | | | | | | | |
D D M M Y Y Y Y

☐ Common-Law Relationship *(specify date commenced)* | | | | | | | | |
D D M M Y Y Y Y

☐ Birth or Legal Adoption of a Child | | | | | | | | |
D D M M Y Y Y Y

b) I am eligible to exercise the FIG Option within 60 days of my birthday (up to and including age 55):

☐ For DisabilityGuard™ insurance

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

If "Yes", please provide full details._____

_____

Complete questions 3 and 4 only if applying for additional Basic Life coverage under the Future Insurance Guarantee Option.

3. Amount of increase applied for under Basic Life coverage: $_____

Note: You are eligible to apply for the lesser of the amount of coverage currently in force or $50,000. Total coverage must not exceed the current plan maximum.

4. Waiver of Premium Option on Basic Life coverage: *(available if you currently carry this option)*
This option will be automatically applied to your additional coverage. If you do not want this option applied to your additional coverage, check here: ☐

Complete question 5 only if applying for additional DisabilityGuard™ coverage under the Future Insurance Guarantee Option.

5. 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? Will any such insurance be discontinued if this coverage applied for is issued?

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

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

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.

Please return <u>all</u> pages of this application.

Section 3 Future Insurance Guarantee Option information (continued)

6. Amount of coverage applied for* under the FIG Option for DisabilityGuard™ **(do not include existing coverage)** 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

Note: Coverage will be issued with the same premium option as your current coverage.

* You are eligible to apply for up to 25% of the amount of your coverage (Step or Level) (rounded to the next higher $100). Total DisabilityGuard™ Insurance coverage (in force and applied for) must not exceed the FIG Option maximum or the current plan maximum. You must financially qualify for increased coverage under the Income Ratio Guide at the time you apply for this coverage. **Any options on your current coverage will be applied to your additional coverage (except the FIG Option).**

** The elimination period(s) that currently apply to your coverage will be applied in the same proportions to your new coverage.

7. Amount of FIG Option increase applied for under FIG Option for Office Overhead Expense **(do not include existing coverage)** in increments of $100:

Elimination Period†	Payment Option #1 (Reducing)	Payment Option #2 (Fixed)	Benefit Period
14-Day	$	$	☐ 12-month **or** ☐ 24-month
14-Day	$	$	☐ 12-month **or** ☐ 24-month
30-Day	$	$	☐ 12-month **or** ☐ 24-month
30-Day	$	$	☐ 12-month **or** ☐ 24-month

Note: You are eligible to apply for up to 25% of the amount of your OOE coverage that includes the FIG Option (rounded to the next higher $100). Total Office Overhead Expense Insurance coverage (in force and applied for) must not exceed the current plan maximum or your Total Monthly Overhead Expenses.

† The elimination period(s) that currently apply to your Office Overhead coverage will be applied in the same proportions to your new coverage. The Own Occupation Option will be included if you currently have this option.

Please return all pages of this application.

Section 4 Financial Information

Complete the following questions only if exercising the FIG Option for DisabilityGuard™ insurance or Office Overhead Expense insurance coverage.

1. 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:
If your **total*** disability or Office Overhead Expense coverage will exceed $4,000/month, please provide copies of your last personal tax return (a Notice of Assessment is not adequate). 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 of total* disability coverage
- If you are applying for $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.

Complete the following questions only if exercising FIG for Office Overhead Expense coverage.

F. Number of employees: Full-time _____ Part-time _____

G. ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Associate
If a shareholder, employee of a professional corporation or a partner, give percentage of ownership:_____%

H. Total number of Partners, Shareholders or Associates in practice:_____

I. If expenses shared, your share: _____%
Note: If expenses are shared, include a copy of expense sharing agreement with this application.

Average Monthly Expenses for Professional Practices (your portion)

Accounting Services $ _____
Interest on Loans, Depreciation/Rental $ _____
Business Insurance Premiums $ _____
Association Membership Dues $ _____
Rent/Mortgage Interest Payments $ _____
Employee Salaries and Benefits $ _____
(Do not include salary paid to yourself or any member of your profession or any income splitting with a family member)
Telephone, Internet Service, Answering Service $ _____
Utilities (Electricity, Heat, Laundry, Office Maintenance) $ _____
Other customary and reasonable fixed expenses incurred $ _____
Please list: _____

Total All Items:
Your Share of Total Average Monthly Overhead Expenses $ _____

(Total coverage in force and applied for may not exceed this amount.)
Note: Eligible Office Overhead Expenses are expenses incurred in the practice of dentistry only, and not any other type of business.

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Please return all pages of this application.

Section 5 Beneficiary Designation

Note: If you need more space, please use a separate signed and dated sheet of paper, and attach it to this form.

Complete this section only if exercising FIG Option for Basic Life coverage.

1. Below, list a primary beneficiary (or beneficiaries) and contingent beneficiaries (if applicable).

If a beneficiary is designated as revocable, you will be able to change the beneficiary and make other changes to the coverage at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent will be required in order to change the beneficiary, reduce coverage, cancel the policy or make any other changes that may affect the value or ownership of the policy.

Except for the designation of a spouse as beneficiary in Quebec, a beneficiary designation will be revocable unless you make it irrevocable by checking the box in the "irrevocable" column below. In Quebec, the designation of a spouse as beneficiary is deemed irrevocable, unless you specify that the designation is revocable by checking the box in the Quebec column below.

If you name more than one primary beneficiary, please record the percentage of the death benefit each beneficiary is to receive. If no percentage is recorded, the death benefit will be divided evenly among the surviving eligible primary beneficiaries. You may also name one or more contingent beneficiaries who will receive a death benefit only if:
a) no primary beneficiaries are alive when the benefit is payable; or
b) a court decides that the primary beneficiaries are not eligible.

Note: If sufficient space is not available, please check here ☐ and complete a separate signed and dated sheet to be attached to this form. Please follow the format used in the box below, including percentage distribution if naming multiple beneficiaries.

		Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Portion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Basic Life	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
	Contingent Beneficiary				N/A	☐
				Total 100%		

2. If you named a minor as a beneficiary in the previous section, please provide the name of the trustee appointed to receive any payment due to the minor beneficiary, in the event of the death of the Person To Be Insured.

A. Minor Beneficiary Name: _____

B. Trustee Name: _____

C. Relationship to Beneficiary: _____

D. **For Quebec residents only:** In the province of Quebec, if you designate a beneficiary who is under the age of 18 when benefits become payable, benefits will be paid to the tutor or administrator of the beneficiary and no trustee may be appointed.

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

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 (including CDSPI and CDSPI Advisory Services Inc.) 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.

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Please return <u>all</u> pages of this application.

DECLARATION AND AUTHORIZATION

Section 6 — To Be Read, Signed and Dated By the Applicant (and Person To Be Insured if other than the Applicant)

I/We apply to The Manufacturers Life Insurance Company (Manulife) for the insurance indicated above under the group policies 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 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. Suicide within two (2) years of the effective date or reinstatement date is a risk not covered. 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 on my life and well-being.

I/We acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ Date: | | | | | | | | |
Signature of Person To Be Insured (if other than the Applicant) — D D M M Y Y Y Y

Signed at: _____
City / Town — Province / Territory

_____ Date: | | | | | | | | |
Signature of Applicant — D D M M Y Y Y Y

Signed at: _____
City / Town — Province / Territory

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