CDSPI ADVICE. INSURANCE. INVESTMENTS.

Provided by Manulife

APPLICATION FOR
Family Life Insurance

Membership Requirements for New Coverage: Licensed dentists must be members of the CDA or a participating provincial or territorial dental association in order for family members or the dentist to be eligible to apply for coverage.

Membership Requirements for Existing Coverage: If you are making a change to an existing policy, there are no membership eligibility requirements.

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.

SECTION 1 Applicant Information

A. Name (please print)

Check one ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Corporation

Last Name (Or name of partnership or corporation)

First Name | Initial

B. Individuals only ☐ Male ☐ Female

C. Mailing Address Check one ☐ Home ☐ Business

Street and Number | Apt/Suite

City/Town | Province | Postal Code

Home Phone | Business Phone

Cell Phone | Fax

Email Address (Not mandatory but may expedite application process)

D. Account Number (if known)

Payment Frequency (Choose One):

☐ Same as current
(Only applies if you are an existing client paying premiums)

☐ Annual

☐ Quarterly*

☐ Monthly*

(If paying monthly, you must select Automatic Payments under the Payment Method section below)

*A 2.23% processing charge applies to monthly and quarterly payments.

Payment Method (Choose One):

☐ Invoice (Will be mailed to your address on file for payment).

☐ Automatic Payments

- ☐ Pre-authorized Chequing Plan (PAC) – Please complete a Pre-Authorized Chequing Plan Form
- ☐ VISA/MasterCard – CDSPI will contact you for credit card details upon receipt of your application

E. Language Preference ☐ English ☐ French

PLAN UNDERWRITTEN BY THE MANUFACTURERS LIFE INSURANCE COMPANY

SECTION 2 Person To Be Insured

A. Status of Applicant (check one)

1. ☐ Licensed Dentist who is a member of
   - ☐ A participating Provincial/Territorial Dental Association
   - ☐ CDA

Provincial/CDA License Number **(mandatory)**

Date of Graduation ☐☐ ☐☐ ☐☐☐☐
(DD/MM/YYYY)

Name of University or Dental Faculty

Dental Specialty

2. ☐ Non-Dependent Adult Child of Eligible Dentist

Name of Licensed Dentist who is a member of a participating Provincial/Territorial Dental Association or the CDA

Dentist's Provincial/CDA License Number **(mandatory)**

3. ☐ Spouse of Non-Dependent Adult Child of Eligible Dentist

Name of Licensed Dentist who is a member of a participating Provincial/Territorial Dental Association or the CDA

Dentist's Provincial/CDA License Number **(mandatory)**

4. ☐ Employee of Dental Association

Name of Association

5. ☐ Other (please specify) _____

B. Occupation _____
(if not a dentist)

SECTION 3 Family Life Insurance

A. Type of coverage required

- ☐ Spousal coverage (Complete Sections 4, 7, 8, 9 and 10)
- ☐ Spouse and Dependent Children coverage (Complete Sections 4, 6, 7, 8, 9 and 10)
- ☐ Dependent Children Only coverage (Complete Sections 6, 8 and 10)

  NOTE: You (the Applicant) are required to have Basic Life Insurance to apply for this coverage. Dependent Children Only coverage is only available if you (the Applicant) do not have a spouse or if your spouse does not qualify medically for life insurance.
- ☐ Non-Dependent Adult Child coverage (Complete Sections 5, 7, 8, 9 and 10)
- ☐ Non-Dependent Adult Child coverage – Spousal coverage (Complete Sections 5, 7, 8, 9 and 10)

B. 1. Amount of insurance applied for at this time

$ _____
(do not include existing coverage)

2. If applicable, would you like the Waiver of Premium Option? (Check box if "Yes") ☐

C. 1. Do you have any existing Family Life Insurance coverage through CDSPI?

☐ Yes ☐ No

2. If "Yes", would you like to apply to be considered for the AdvantEdge rates* on your existing Family Life Insurance coverage?

☐ Yes ☐ No

*To be eligible for AdvantEdge rates you must meet the following criteria: • Be under the age of 70, • Have no plan to and have not been advised to consult a physician or specialist or have a diagnostic test or surgery performed (excluding routine physicals), • Have not used any form of tobacco or tobacco cessation products in the past 12 months, • Have not been declined for life insurance or offered coverage on a modified basis in the past five years, • Have not received treatment for cancer, coronary artery disease, stroke, diabetes, lung, liver or kidney disorder, HIV infection, AIDS or any other significant medical disorder in the past five years and, • Have not used any form of illicit drug, or been treated for or advised to reduce alcohol or drug usage in the past five years.

Note, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

SECTION 4 Spouse To Be Insured Under Family Coverage

A. Name (please print)
Check one ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name

First Name Initial

B. ☐ Male ☐ Female

C. ☐ Smoker ☐ Non-Smoker†

D. Date of Birth ____ ____ ____ (DD/MM/YYYY)

Place of Birth Country Province

E. Occupation _____

F. Spouse's Annual Net Earned Income

$ _____
(after expenses but before taxes)

Spouse's Personal Net Worth

$ _____
(Assets less liabilities)

† 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. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

SECTION 5 Non-Dependent Adult Child & Spouse of Non-Dependent Adult Child To Be Insured Under Family Coverage

Non-Dependent Adult Child

A. Name (please print)

Last Name

First Name Initial

B. ☐ Male ☐ Female

C. ☐ Smoker ☐ Non-Smoker†

D. Date of Birth ____ ____ ____ (DD/MM/YYYY)

Place of Birth Country Province

E. Occupation _____

F. Non-Dependent Adult Child's Annual Net Earned Income

$ _____
(after expenses but before taxes)

Non-Dependent Adult Child's Personal Net Worth

$ _____
(Assets less liabilities)

Spouse of Non-Dependent Adult Child

A. Name (please print)

Last Name

First Name Initial

B. ☐ Male ☐ Female

C. ☐ Smoker ☐ Non-Smoker†

D. Date of Birth ____ ____ ____ (DD/MM/YYYY)

Place of Birth Country Province

E. Occupation _____

F. Spouse of Non-Dependent Adult Child's Annual Net Earned Income

$ _____
(after expenses but before taxes)

Spouse of Non-Dependent Adult Child's Personal Net Worth

$ _____
(Assets less liabilities)

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

† 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. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

SECTION 6 Dependent Children To Be Insured Under Family Coverage

Dependent, unmarried children to age 21 (or unmarried children under age 25 if full-time students)

First Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Smoker ☐ Non-Smoker†

D. Date of Birth (DD/MM/YYYY)

E. If over 21, full-time student? ☐ Yes ☐ No

If "Yes", Program End Date (DD/MM/YYYY)

Second Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Smoker ☐ Non-Smoker†

D. Date of Birth (DD/MM/YYYY)

E. If over 21, full-time student? ☐ Yes ☐ No

If "Yes", Program End Date (DD/MM/YYYY)

NOTE: If you need more space for additional children, use a separate signed and dated sheet of paper and attach it.

† You are considered a non-smoker if you have not used any form of tobacco or tobacco cessation products in the last 12 months prior to signing this application. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

SECTION 7 Replacement of Other Life Insurance

To be completed by the Person To Be Insured, their spouse, and non-dependent adult child and their spouse, if applying

A. 1. Does any person applying for coverage (other than dependent adult children) have any pending or existing life insurance coverage with CDSPI or any other company (other than coverage you may have through your employer)? ☐ Yes ☐ No

2. If "Yes", please provide details

NAME OF APPLICANT (FIRST & LAST)	NAME OF COMPANY	AMOUNT OF COVERAGE ($)	PERSONAL OR BUSINESS	DO YOU INTEND TO REPLACE THIS COVERAGE?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NOTE: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

SECTION 8 Beneficiaries

A. Below, list the primary beneficiaries and contingent beneficiaries **only** for the plans for which you are applying.

NOTE: If purchasing additional coverage, this beneficiary designation relates only to the additional coverage being purchased. Beneficiary designations for coverage already issued will remain in force as is.

If a beneficiary is designated as revocable, you (the Owner) 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 (the Owner) make it irrevocable** (for reasons such as satisfying the requirements of a divorce judgment, separation agreement, court order or partnership insurance agreement) by checking the box in the "irrevocable" column below. In Quebec, the designation of a spouse as beneficiary is deemed irrevocable, **unless you (the Owner) specify** that the designation is revocable by checking the box in the Quebec column below.

If you (the Owner) name more than one primary beneficiary, please record the percentage of the death beneft each beneficiary is to receive. If no percentage is recorded, the death beneft will be divided evenly among the surviving eligible primary beneficiaries. You (the Owner) may also name one or more contingent beneficiaries who will receive a death beneft only if: a) no primary beneficiaries are alive when the beneft 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 and attach to this form. Please follow the format used below, including percentage distribution if naming multiple beneficiaries.

FAMILY LIFE INSURANCE		NAME IN FULL (LAST, FIRST & INITIAL)	RELATIONSHIP TO PERSON TO BE INSURED	PROPORTION (%)	CHECK **ONLY** IF MAKING IRREVOCABLE (SEE ABOVE)	IN QUEBEC, CHECK IF MAKING A SPOUSE A REVOCABLE BENEFICIARY
FAMILY LIFE INSURANCE (SPOUSE)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐
FAMILY LIFE INSURANCE (DEPENDENT CHILD)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐
FAMILY LIFE INSURANCE (NON-DEPENDENT ADULT CHILD)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐
FAMILY LIFE INSURANCE (SPOUSE OF NON-DEPENDENT ADULT CHILD)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐

B. If you designate a beneficiary who is a minor when benefits become payable, benefits will be payable into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Beneficiary Name

Trustee Name

Relationship of Trustee to Person To Be Insured

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

C. **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.

SECTION 9 Declaration of Insurability

IMPORTANT: If a Non-Dependent Adult Child and his/her spouse are applying, both applicants are required to complete Section 9. Make a photocopy of Section 9 and complete all questions. Sign, date and attach the photocopy to the application. (You may also contact CDSPI to obtain an extra copy of Section 9.)

QUEBEC RESIDENTS ONLY:
For Quebec residents, please fill out this box only if detaching Section 9 (see note for Quebec residents at the end of Section 9):

Last Name (Person To Be Insured)

First Name | Initial

Date of Birth (DD/MM/YYYY)

Date Applicant Signed (DD/MM/YYYY)

TO BE COMPLETED BY THE PERSON TO BE INSURED

A. Personal Information

▶ Have you:

1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason. ☐ Yes ☐ No

2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked. ☐ Yes ☐ No

   b) Within the past 3 years, been charged with or convicted of two or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving or failure to provide a breathalyzer sample)? If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province. ☐ Yes ☐ No

3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s). ☐ Yes ☐ No

Within the next 12 months:

4. a) Any travel plans for travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long. ☐ Yes ☐ No

   b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing. ☐ Yes ☐ No

Within the past 5 years:

5. a) Used any drugs for other than medical purposes, used marijuana, or been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug(s) used, alcohol type(s), daily consumption and date(s) last used. ☐ Yes ☐ No

   b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details. ☐ Yes ☐ No

   c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge. ☐ Yes ☐ No

▶ **If you answered yes to any part(s) of questions 1 to 5, please provide details below.**

QUESTION NO. AND PART	APPLICABLE DATE (DD/MM/YYYY)	ALL APPLICABLE DETAILS

IMPORTANT: Any reference to testing, tests, test results or investigations in this section excludes genetic tests. Genetic tests means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

B. Medical Information

Name of Physician

Phone

Street and Number | Apt/Suite

City/Town | Province | Postal Code

Height _____ ☐ ft/in ☐ m/cm Weight _____ ☐ lb ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No

If yes, provide reason for change below:

Gained _____ ☐ lb ☐ kg Lost _____ ☐ lb ☐ kg

▶ **Date, reason and result of last consultation, and if any treatment or medication prescribed.**

SECTION 9 Declaration of Insurability (continued)

C. Health Conditions, Disorders and Treatments

▶ Have you:

6. Ever had any indication of or been treated for conditions involving any of the following:

a) **Your heart or blood vessels,** such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other? ☐ Yes ☐ No

b) **Your nose, throat or lungs,** such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other? ☐ Yes ☐ No

c) **Your abdominal organs,** such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other? ☐ Yes ☐ No

d) **Your kidneys, bladder or reproductive organs,** such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other? ☐ Yes ☐ No

e) **Your breast,** such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other? ☐ Yes ☐ No

f) **Your brain or nervous system,** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other? ☐ Yes ☐ No

g) **Your eyes or ears,** such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other? ☐ Yes ☐ No

h) **Your mental health,** such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other? ☐ Yes ☐ No

i) **Your blood or glands,** such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other? ☐ Yes ☐ No

j) **Your muscles, bones or joints,** such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other? ☐ Yes ☐ No

k) **Your skin,** such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other? ☐ Yes ☐ No

l) **Your immune system,** such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other? ☐ Yes ☐ No

m) **Cancer, cysts, lumps, polyps, or tumour?** ☐ Yes ☐ No

n) **Other illness or disorder not mentioned above,** or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment? ☐ Yes ☐ No

▶ If female,

7. a) are you currently pregnant? ☐ Yes ☐ No

Due Date | | | | | | | | (DD/MM/YYYY)

b) What was your pre-pregnancy weight? _____ ☐ lb ☐ kg

c) Have there been any complications with your pregnancy? If yes, provide details. ☐ Yes ☐ No

Name of Obstetrician/Gynecologist

Phone

Address Apt/Suite

City/Town Province Postal Code

▶ Within the past 2 years:

8. a) Had an abnormal mammogram, PSA or any other test or investigation? ☐ Yes ☐ No

b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)? ☐ Yes ☐ No

c) Been advised to undergo further investigation, see another doctor or have surgery? ☐ Yes ☐ No

d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness? ☐ Yes ☐ No

SECTION 9 Declaration of Insurability (continued)

MEDICAL INFORMATION DETAILS

▶ If you answered yes to any of the questions in the section titled Health Conditions, Disorders and Treatments, please provide details in the table below. If more space is required, please attach a separate sheet (dated and signed).

QUESTION NO. AND PART	APPLICABLE DATE (DD/MM/YYYY)	ALL APPLICABLE DETAILS (Include name and address of physician/hospital, if any, and also all information as to the nature of the illness or injury, symptoms, number of attacks, duration, treatment and results)

D. Family Medical History

9. Have any of your parents or siblings (brothers or sisters):

a) Been diagnosed prior to age 60 with heart disease, stroke or cancer? ☐ Yes ☐ No

b) Been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis or retinitis pigmentosa? ☐ Yes ☐ No

▶ **If you answered yes to question a) or b) above, please complete the following**

FAMILY MEMBER	CONDITION (if cancer, specify type)	AGE AT ONSET	AGE AT DEATH AND CAUSE (if applicable)

SECTION 9 Declaration of Insurability (continued)

QUEBEC RESIDENTS ONLY: When your completed application is returned to CDSPI, Section 7 will be detached and sent to Manulife and no file copy will be retained at CDSPI's offices. However, you also have the choice of detaching Section 7 of this application and submitting it directly to Manulife. If you wish, you may complete the entire application and mail Section 7 only to the following address: **ATTN: Affinity Markets Program Underwriting Department, Manulife, P.O. Box 670, Stn. Waterloo, Waterloo, Ontario N2J 4B8**. All other sections of the completed application must be mailed to: **CDSPI, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4**.

If you are detaching Section 9 and mailing it directly to Manulife, please complete the name of the Person To Be Insured, their date of birth and the CDA membership number of the applicant listed in Section 1.

This application will not be considered complete unless a properly completed, signed and dated Declaration of Insurability is received by Manulife.

Last Name (Person To Be Insured)

First Name | Initial

CDA Membership Number (Applicant)

(Person To Be Insured)
Date of Birth (DD/MM/YYYY)

Date Application Signed (DD/MM/YYYY)

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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 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.

SECTION 10 Declaration and Authorization (To be read, signed and dated by applicant/Person To Be Insured)

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

I/We apply to The Manufacturers Life Insurance Company (Manulife) for insurance indicated above under the group policy and/or Master Agreement in connection with CDSPI.

I/We, the undersigned, declare that the statements contained in this application, including the statements in the Declaration of Insurability, 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. I/We understand that any material misrepresentation at the time of application, including misstatement of smoker status, shall render any insurance issued pursuant to this application voidable at the instance of the insured. Suicide within two (2) years of the effective date or reinstatement date is a risk not covered. I/We understand that the insurance will take effect on the date the properly completed application is approved by Manulife, subject to the Person To Be Insured being actively at work on that date and the receipt of payment of the first premium within 30 days of issuance of a premium invoice. I/We understand that any health information must be accurate as of the date the application is signed. I/We understand that Manulife may request a medical examination, urinalysis or tests such as a general blood profile, including blood test for HIV, which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department, if required by law. I/We acknowledge receipt of and confirm my/our agreement with the Notice on Privacy and Confidentiality and the Notice on Exchange of Information. Relative to the insurance applied for, I, the Person To Be Insured, authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB Group, Inc., the group policy administrator, the insurance plan sponsor, any investigative and security agency, any credit bureau or credit reporting agency, any agent, broker or market intermediary, any government agency or other organization or person (including my accountant) that has any records or knowledge of me, my health or my finances to provide to Manulife or its reinsurers any such information for the purposes of this application and contract and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose. I/We authorize Manulife to obtain a credit report and/or a consumer report. I/We declare that I/we 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/We understand that 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. A photocopy or facsimile of this authorization shall be as valid as the original.

NOTE: Eligibility for coverage is limited to Canadian citizens or permanent residents of Canada who are licensed dentists in Canada, or spouses and children of licensed dentists in Canada who are members of the CDA or participating provincial or territorial dental association (in Quebec, only CDA members are eligible) or full-time employees of a participating Canadian dental association or organization.

Signature of Person To Be Insured (if other than the Applicant)	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Applicant	Date (DD/MM/YYYY)	Signed at: City	Province
Spouse's Signature	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Child (if child is 18 years of age or older)	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Non-Dependent Adult Child	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Spouse of Non-Dependent Adult Child	Date (DD/MM/YYYY)	Signed at: City	Province

Manulife

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NOTICE ON EXCHANGE OF INFORMATION — MUST BE DETACHED, READ AND RETAINED BY THE PERSON TO BE INSURED

Information regarding your insurability will be treated as confidential. Manulife or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Manulife or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416.597.0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. Information for consumers about MIB may be obtained on its website at www.mib.com.