APPLICATION

Basic Life Insurance and Family Life Insurance/ Accidental Death and Dismemberment Insurance

CDSPI ADVICE. INSURANCE. INVESTMENTS.

16-96099001

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1-800-561-9401 (toll-free) or (416) 296-9401, E-mail: 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 (toll-free) or (416) 296-8920

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name (*please print*):
Check one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Corporation

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

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. A. Account Number, if known: ⌊ | | | | | ⌋

B. Billing Preference (*check one*):
- ☐ Same as current
- ☐ Annually
- ☐ Quarterly
- ☐ Monthly
- ☐ Pre-authorized Chequing*
- ☐ Automatic VISA/MasterCard*

** To pay monthly, quarterly or annually under this option, you must complete and send in a pre-authorized payment plans form. To obtain this form, visit www.cdspi.com/pac-insurance.*

Note: A 2.23 per cent processing charge applies to monthly and quarterly payments.

7. Language Preference: ☐ English ☐ French

Section 2 Status of Applicant

1. STATUS (*check one*):

A. ☐ Dentist
- ☐ Member of Provincial/Territorial Dental Association*
- ☐ Member of CDA

* Excluding the ACDQ in Quebec.

Date of Graduation: ⌊ | | | | | | | | ⌋
Day Month Year

Name of University or Dental Faculty: _____

Dental Specialty: _____

B. ☐ Dental Student

Name of University or Dental Faculty: _____

C. ☐ Non-Dependent Adult Child of Eligible Dental Association Member Dentist

Name of Dentist: _____

D. ☐ Spouse of Non-Dependent Adult Child of Eligible Dental Association Member Dentist

Name of Dentist: _____

E. ☐ Employee of Dental Association

Name of Association: _____

F. ☐ Other (please specify): _____

2. Occupation (if not a dentist or dental student): _____

COVERAGE APPLIED FOR

Section 3 Basic Life Insurance

Note: Please complete even if the person to be insured is the same as the applicant. **The person to be insured must be under age 65**.

1. Name: (*please print*):
Check one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Smoker ☐ Non-Smoker†

4. Date of Birth: Day Month Year

5. Country of Birth: _____

6. Amount of insurance applied for at this time **(do not include existing coverage)**:

$ _____

(Please use $25,000 increments.)

A. Would you like the Future Insurance Guarantee Option?
(check if "Yes") ☐ Yes

B. Would you like the Waiver of Premium Option?
(check if "Yes") ☐ Yes

7. Complete the following if your existing and applied for coverage will exceed a total of $250,000:

Annual Net Earned Income (after expenses but before taxes):

$ _____

Personal Net Worth (Assets less liabilities):

$ _____

8. A. Do you have any existing Basic Life Insurance coverage through the Canadian Dentists' Insurance Program?
(check if "Yes") ☐ Yes

B. If "Yes", would you like to apply to be considered for the AdvantEdge rates* on your existing Basic Life Insurance coverage?
(check if "Yes") ☐ Yes

* You must be a Non-Smoker to be considered for the AdvantEdge rates.

Please complete Section 12.

† Note: 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 4 Family Life Insurance

1. Type of coverage required:

☐ Spousal coverage **(Complete Sections 5, 8, 10, 11 and 13)**

☐ Spouse and Dependent Children coverage **(Complete Sections 5, 7, 8, 10, 11 and 13)**

☐ Dependent Children Only coverage **(Complete Sections 7, 10 and 11)**
(Note: Children Only coverage is only available if you do not have a spouse or if you or your spouse do not qualify medically for life insurance)

☐ Non-Dependent Adult Child coverage **(Complete Sections 6, 8, 10, 11 and 13)**

☐ Non-Dependent Adult Child coverage – Spousal coverage **(Complete Sections 6, 8, 10, 11 and 13)**

2. Amount of insurance applied for at this time (**do not include existing coverage**):

$ _____

A. If applicable, would you like the Waiver of Premium Option?
(check if "Yes") ☐ Yes

3. A. Do you have any existing Family Life Insurance coverage through the Canadian Dentists' Insurance Program?
(check if "Yes") ☐ Yes

B. If "Yes", would you like to apply to be considered for the AdvantEdge rates* on your existing Family Life Insurance coverage?
(check if "Yes") ☐ Yes

* You must be a Non-Smoker to be considered for the AdvantEdge rates.

Section 5 Spouse To Be Insured Under Family Life Coverage and AD&D (if Applying for AD&D Family Coverage in Section 9)

Note: The person to be insured must be under age 65.

1. Name (*please print*):
Check one: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Smoker ☐ Non-Smoker†

4. Date of Birth: Day Month Year

5. Country of Birth: _____

6. Occupation: _____

7. Complete the following if your spouse's existing and applied for coverage will exceed a total of $250,000:

Spouse's Annual Net Earned Income (after expenses but before taxes):

$ _____

Spouse's Personal Net Worth (Assets less liabilities):

$ _____

† Note: 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 Non-Dependent Adult Child and Spouse of Non-Dependent Adult Child To Be Insured Under Family Life Coverage and AD&D (if Applying for AD&D Family Coverage in Section 9)

Note: The person to be insured must be under age 65.

Name (Last, First, Middle or Middle Initial)	Title (Dr., Mr., Mrs., Miss, Ms)	Male or Female	Smoker or Non-Smoker†	Date of Birth (dd/mm/yyyy)	Country of Birth	Occupation	Annual Net Earned Income (if existing and applied for coverage totals more than $250,000)

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

Section 7 Dependent Children To Be Insured Under Family Life Coverage and AD&D (if Applying for AD&D Family Coverage in Section 9)

FAMILY LIFE: Dependent, unmarried children to age 21 (or unmarried children under age 25 if full-time students) **and/or**

FAMILY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): Dependent, unmarried children under age 23 (or unmarried children under age 27 if full-time students)

First Child

1. Name (*please print*):

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Married ☐ Unmarried

4. Date of Birth: Day Month Year

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

If "Yes", Program End Date: Day Month Year

Second Child

1. Name (*please print*):

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Married ☐ Unmarried

4. Date of Birth: Day Month Year

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

If "Yes", Program End Date: Day Month Year

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

Section 8 Replacement of Other Life Insurance

To be completed by the person to be insured, their spouse, and non-dependent adult child and spouse, if applying

1. A. Does any person applying for coverage (other than dependent adult children) have any pending or existing life insurance coverage other than through the Canadian Dentists' Insurance Program?
☐ Yes ☐ No

B. If "Yes", please provide details:

Name (First & Last)	Insuring Company	Amount of Coverage	Is coverage pending (P) or existing (E)? Choose one box below.	Do you intend to replace this coverage?
			☐ P ☐ E	☐ Yes ☐ No
			☐ P ☐ E	☐ Yes ☐ No
			☐ P ☐ E	☐ Yes ☐ No

Section 9 Accidental Death and Dismemberment (AD&D) Insurance

1. Type of coverage required: ☐ Single ☐ Family

2. Amount of insurance applied for at this time (**do not include existing coverage**):

$ _____

(Minimum coverage is $50,000. Please use $10,000 increments.)

Section 10 Beneficiaries

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

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 (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 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 and attach to this form. Please follow the format used below, including percentage distribution if naming multiple beneficiaries.

		Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
A. Basic Life Insurance	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
B. Family Life Insurance (spouse)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
C. Family Life Insurance (dependent child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
D. Family Life Insurance (non-dependent adult child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
E. Family Life Insurance (spouse of non-dependent adult child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
F. AD&D Insurance (insured)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
G. AD&D Insurance (spouse)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐
H. AD&D Insurance (dependent child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
				Total 100%		
	Contingent Beneficiary				N/A	☐

Please complete Question 2 on the next page if you have named a minor as a beneficiary.

2. If you named a minor as a beneficiary in the previous question, 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. Beneficiary Name: _____

B. Insurance Plan:
☐ Basic Life ☐ Family Life ☐ AD&D

C. Trustee Name: _____

D. 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 to this form.

DECLARATION AND AUTHORIZATION

Section 11 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 policy and/or certificate booklet containing a detailed description of coverage and limitations.

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

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 policy or Certificate of Insurance issued. 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 (2) years of the effective date or last reinstatement date is a risk not covered. I/we understand that insurance will take effect on the date the properly completed application is approved by Manulife Financial, subject to payment of the first premium within 30 days of issuance of a premium invoice, and, for Basic Life Insurance, subject to the person to be insured being actively at work on that date. I/we understand that any health information must be accurate as of the date the application is signed.

If the applicant is other than myself, I (the person to be insured) consent to the issuance of insurance on my life.

I (the applicant) designate the individual(s) named as beneficiary in this application to receive any death benefits payable and reserve the right to revoke or alter the interest of any beneficiary named in this application, subject to any applicable law.

I acknowledge receipt of and confirm my 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 or parent/guardian if the person to be insured is a minor child, authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB Group Inc., 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 or the health of any member of my family to be insured under this plan to provide to Manulife Financial or its reinsurers any such information for the purposes of this application and contract and any subsequent claim. I authorize Manulife Financial to consult its existing files for this purpose. 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. This consent shall take effect on the date of signing this application and shall expire seven (7) years after the termination date of any policy or coverage described in a Certificate of Insurance issued as a result of this application. 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.

QUEBEC PARTICIPANTS ONLY

Les parties ont expressément convenu que la présente entente ainsi que tous annexes ou documents s'y rattachant soient rédigés en anglais.
(The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.)

NOTE : Ce document est aussi disponible en français.

NOTE: 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: City/Town	Province
Signature of Applicant	Date: Day Month Year	Signed at: City/Town	Province
Spouse's Signature (if Family Insurance is applied for)	Date: Day Month Year	Signed at: City/Town	Province
Signature of Child (if Family Insurance is applied for and child is 18 years of age or older)	Date: Day Month Year	Signed at: City/Town	Province
Signature of Non-Dependent Adult Child (if Family Insurance is applied for)	Date: Day Month Year	Signed at: City/Town	Province
Signature of Spouse of Non-Dependent Adult Child (if Family Insurance is applied for)	Date: Day Month Year	Signed at: City/Town	Province

QUEBEC RESIDENTS ONLY: If you have chosen to send Sections 12 and 13 directly to Manulife Financial, please indicate the date you sent Sections 12 and 13 to Manulife:

Date: Day Month Year

DECLARATION OF INSURABILITY

Section 12 Basic Life Insurance

In Quebec, please fill out this box if detaching this Declaration of Insurability, Sections 12 & 13 (see note on last page):

Name of Person To Be Insured: | CDA Membership Number: | Date of Birth: | Application Date:

Last First Middle or Middle Initial

Day Month Year Day Month Year

Name of Applicant: | CDA Membership Number: | Date of Birth: | Application Date:

Last First Middle or Middle Initial

Day Month Year Day Month Year

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.**

To be completed by the Person To Be Insured

1. A. Name, Address and Phone Number of your Regular Attending Physician (or Medical Clinic if you don't have a Regular Attending Physician):

B. Date and reason last consulted:

Date (dd/mm/yy): _____

Reason: _____

C. Did any symptoms prompt this visit? ☐ Yes ☐ No

D. Diagnosis, treatment given or medication prescribed (if none, state "None"):

E. Results and current status:

2. A. Have you ever had Life, Disability or Critical Illness Insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or have you ever been denied renewal or reinstatement?
☐ Yes ☐ No

B. Are you currently receiving disability benefits or have you ever made a claim, received benefits, pension or compensation due to sickness or accident?
☐ Yes ☐ No

C. Have you been disabled for a total of 6 months or more in the past 5 years?
☐ Yes ☐ No

D. If you answered "Yes" to A, B or C please provide details, including dates:

3. A. Within the past 5 years, have you piloted an aircraft or do you intend to do so?
☐ Yes ☐ No

B. Within the past 5 years, have you participated in scuba diving, parachuting, hang-gliding, motor vehicle racing, mountain climbing or any other hazardous or extreme sport or activity or do you intend to do so?
☐ Yes ☐ No

C. Within the past 3 years, have you had your driver's licence suspended or been convicted of any moving violations?
☐ Yes ☐ No

D. If you answered "Yes" to A, B or C, please provide details, including dates: _____

4. A. Have you any intention of residing outside of Canada or the United States within the next 12 months?
☐ Yes ☐ No

B. If "Yes", please list country(ies), purpose, departure date(s) and length of stay:

5. A. Height: _____ m _____ cm or _____ ft _____ in

B. Weight: _____ kg or _____ lb

C. Any weight change in the last year? ☐ Yes ☐ No

Indicate amount of change, if any: _____ kg or _____ lb
☐ Loss ☐ Gain

Reason: _____

6. Have you during the past 5 years:

A. Consulted any physician, chiropractor, psychologist, physiotherapist, psychiatrist or other health care professional or been admitted to any hospital or similar institution?
☐ Yes ☐ No

B. Had any symptoms or adverse findings or were you advised to have further examinations, diagnostic tests, hospitalization or surgery not yet done?
☐ Yes ☐ No

C. Submitted to ECG, blood tests, X-rays or other diagnostic tests?
☐ Yes ☐ No

D. Had any surgical operation, treatment, special diet, illness, ailment, abnormality or injury?
☐ Yes ☐ No

7. Do you have any disease or physical impairment or are you receiving any treatment at the present time, to the best of your knowledge and belief?
☐ Yes ☐ No

8. Do you contemplate any medical or surgical treatment?
☐ Yes ☐ No

9. Have you ever had or been treated for any disease or disorder of:

A. The heart or blood vessels, such as heart murmur, heart palpitations, heart disease, heart attack, angina, chest pain, circulatory problems, phlebitis, stroke or high blood pressure?
☐ Yes ☐ No

B. The chest, lungs, nose, or throat, such as asthma, chronic bronchitis or emphysema?
☐ Yes ☐ No

C. The digestive system, including stomach, intestines, gall bladder, liver or pancreas, such as ulcer, colitis, bleeding or hepatitis (including carrier state)?
☐ Yes ☐ No

D. The kidneys, bladder, or reproductive organs, such as nephritis, sugar, albumin, blood in urine or sexually transmitted disease?
☐ Yes ☐ No

E. The nervous system, eyes, or ears, such as dizziness, numbness or tingling, headache, seizure, paralysis, mental and nervous disorder (including depression or stress), chronic fatigue or impairment of sight or hearing?
☐ Yes ☐ No

F. The glandular system or blood, such as diabetes, thyroid, anemia, leukemia, disorder of the breast or skin?
☐ Yes ☐ No

G. The immune system, such as persistent lymph gland enlargement, unusual infections, any other immune system abnormality, or had a positive test related to HIV or been diagnosed with AIDS?
☐ Yes ☐ No

H. The musculoskeletal system, such as chronic pain, fibromyalgia, thoracic outlet syndrome, arthritis, sciatica or defect or pain of the back, neck, bones or joints?
☐ Yes ☐ No

I. Any other illness, disease, operation, cancer, tumour, injury or congenital defect not listed above?
☐ Yes ☐ No

10.A. Are you currently under medical investigation, taking treatment or medication or have you been advised to have or consider treatment or surgery or been referred to another physician?
☐ Yes ☐ No

B. List all over-the-counter and prescription medications you have taken and/or been prescribed in the past 30 days, whether or not they were prescribed by a medical doctor:

_____

11. Are you immunized against Hepatitis B? ☐ Yes ☐ No

12.A. Do you use alcoholic beverages? ☐ Yes ☐ No
If "Yes", please record number of glasses in each category:

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

B. Have you ever consulted a physician, received treatment or medication for, or been advised about excessive alcohol consumption?
☐ Yes ☐ No

C. Have you ever used sedatives, analgesics, hypnotics, tranquillizers and/or stimulants?
☐ Yes ☐ No

D. In the past 7 years have you used any form of marijuana, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use of drugs, prescribed or non-prescribed?
☐ Yes ☐ No

If "Yes", please provide details, including date last used:

_____

E. Have you ever used any form of tobacco or tobacco cessation products?
☐ Yes ☐ No

If "Yes", please provide product type(s) and date last used:

_____

If you smoke cigars, state number smoked per month: _____

13.A. Have any of your parents, brothers or sisters had any heart disease, diabetes, cancer, stroke, high blood pressure, kidney disease or Huntington's Chorea?
☐ Yes ☐ No

B. If "Yes", please complete the table below:

Family Member	Condition (If Cancer, specify type)	Age at Onset	Age at Death and Cause

14. IF ANY OF QUESTIONS 6 THROUGH 12 ARE ANSWERED "YES", PROVIDE FULL DETAILS BELOW. INCLUDE QUESTION NUMBER, EACH ILLNESS, DISEASE, IMPAIRMENT, INJURY, OPERATION, HOSPITALIZATION, PHYSICAL EXAMINATIONS OR CHECKUPS YOU HAVE HAD AND THE DATES.

Question Number & Part	Date	Name and Address of Physician and Hospital, if any	Include (when applicable) all information as to Nature of Illness or Injury, Symptoms, Number of Attacks, Duration, Treatment and Results

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

All persons to be insured: Please note that the Insurer 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.

Section 13 Family Life Insurance (To be completed by the Spouse or Non-Dependent Adult Child.)

Important: If a Non-Dependent Adult Child and his/her spouse are applying, both applicants are required to complete Section 13. Make a photocopy of Section 13 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 13.)

1. A. Name, Address and Phone Number of your Regular Attending Physician (or Medical Clinic if you don't have a Regular Attending Physician):

_____

_____

B. Date and reason last consulted:

Date (dd/mm/yy): _____

Reason: _____

C. Did any symptoms prompt this visit? ☐ Yes ☐ No

D. Diagnosis, treatment given or medication prescribed (if none, state "None"):

_____

_____

E. Results and current status:

_____

_____

2. A. Height: _____ m _____ cm or _____ ft _____ in

B. Weight: _____ kg or _____ lb

C. Any weight change in the last year? ☐ Yes ☐ No

Indicate amount of change, if any: _____ kg or _____ lb

☐ Loss ☐ Gain

Reason: _____

3. A. Have any of your parents, brothers or sisters had any heart disease, diabetes, cancer, stroke, high blood pressure, kidney disease, Huntington's Chorea or other hereditary disease or genetic disorder?

☐ Yes ☐ No

B. If "Yes", please complete the table below:

Family Member	Condition (If Cancer, specify type)	Age at Onset	Age at Death and Cause

4. Are you in good health and free of any symptoms of illness or disease? If "No", please provide details:

☐ Yes ☐ No _____

_____

5. Is your answer "Yes" to any of questions 2A. through 4B. in Section 12 (**Basic Life Insurance**)? If "Yes", please provide details:

☐ Yes ☐ No _____

_____

6. Is your answer "Yes" to any of questions 6A. through 12E. in Section 12 (**Basic Life Insurance**)? If "Yes", please provide details in table below:

☐ Yes ☐ No

Question Number & Part	Date	Name and Address of Physician and Hospital, if any	Include (when applicable) all information as to Nature of Illness or Injury, Symptoms, Number of Attacks, Duration, Treatment and Results

* Include the Results of all Physical Examinations and Checkups.
Note: If you need more space, please use a separate signed and dated sheet of paper, and attach to this form.

Quebec residents only: When your completed application is returned to CDSPI, SECTIONS 12 & 13 will be detached and sent to Manulife Financial and no file copy will be retained at CDSPI's offices. However, you also have the choice of detaching SECTIONS 12 & 13 of this application and submitting them directly to Manulife Financial. If you wish, you may complete the entire application and mail SECTIONS 12 & 13 only to the following address: ATTN: Affinity Markets/CDA Program Underwriting Department, Manulife Financial, P.O. Box 670, Stn. Waterloo, Waterloo, Ontario N2J 4B8. All other sections of the completed application must be mailed to: CDSPI, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

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

Quebec residents: If you are detaching SECTIONS 12 & 13 and mailing them directly to Manulife Financial, please write below the name of the person to be insured, his/her date of birth and the CDA Membership Number of the applicant listed in SECTION 1.

Name of Person To Be Insured: _____ CDA Membership Number: _____ Date of Birth: ___ ___ ___ Application Date: ___ ___ ___

Last First Middle or Middle Initial Day Month Year Day Month Year

Name of Applicant: _____ CDA Membership Number: _____ Date of Birth: ___ ___ ___ Application Date: ___ ___ ___

Last First Middle or Middle Initial Day Month Year Day Month Year

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 Financial 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 Financial 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, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn. A, Toronto, Ontario M5W 5M3.

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: Information Access Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

NOTICE ON EXCHANGE OF INFORMATION – **Must be detached, read and retained by the person to be insured**

All information requested will be for insurance purposes only and will be treated as confidential. The insurer or its reinsurers may, however, make a brief report on it to the MIB Group, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, MIB will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, MIB will arrange for disclosure to you of any information it may have in your file. If you question the accuracy of MIB's file, you may contact MIB and seek a correction. The address of the MIB's Information Office is: 330 University Avenue, Toronto, Ontario M5G 1R7. Telephone: (416) 597-0590. E-mail: canada_disclosure@mib.com.