APPLICATION

Accidental Death and Dismemberment Insurance

ADVICE. INSURANCE. INVESTMENTS.

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

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96099001

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. Language Preference: ☐ English ☐ French

7. 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.*

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

COVERAGE APPLIED FOR

Section 2 Accidental Death and Dismemberment (AD&D) Insurance

1. Type of coverage required: ☐ Single ☐ Family

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

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

Section 3 Person To Be Insured Under Single Coverage

Note: Please complete even if the person to be insured is the same as the applicant.

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

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. Date of Birth: ⌊ | | | | | | | | ⌋
Day Month Year

4. 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. ☐ Employee of Dental Association
Name of Association: _____

D. ☐ Other (please specify): _____

Section 4 Spouse To Be Insured Under Family Coverage

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

Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. Date of Birth: Day Month Year

Section 5 Dependent Children To Be Insured Under Family Coverage

Dependent, unmarried children under age 23 (or under age 27 if attending school full-time)

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 aged 23 or over, 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 aged 23 or over, full-time student? ☐ Yes ☐ No

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

Third 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 aged 23 or over, full-time student? ☐ Yes ☐ No

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

Fourth 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 aged 23 or over, 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 piece of paper and sign and date it.

Section 6 Beneficiaries

1. Below, list the primary beneficiaries and contingent beneficiaries.

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 to be attached 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. AD&D Insurance (insured)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐
B. AD&D Insurance (spouse)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐
C. AD&D Insurance (child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐

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. Trustee Name: _____

C. Relationship of Trustee to Person To Be Insured: _____

Note: If you need more space, please use a separate piece of paper and sign and date it.

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, ON 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 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 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, ON M3B 2T8.

DECLARATION AND AUTHORIZATION

Section 7 To Be Read, Signed and Dated By the Applicant (and Person To Be Insured if Other than the Applicant)

I hereby apply to The Manufacturers Life Insurance Company (Manulife Financial) for Accidental Death and Dismemberment Insurance as offered under the this Insurance Program. I declare that the statements contained in this application are, to the best of my knowledge and belief, true and complete.

I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality set out below. 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.

_____ Date: Day Month Year Signed at: _____ City/Town Province
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
Signature of Spouse (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)

Manulife Financial
For your future™

Insurer: The Manufacturers Life Insurance Company (Manulife Financial), Affinity Markets, P.O. Box 4213, Stn. A, Toronto, ON M5W 5M3