APPLICATION

For AdvantEdge and AdvantEdge Special Premium Rates for Basic Life or Family Life, or HealthEdge Rates for Long Term Disability or Office Overhead Expense Insurance

CDSPI ADVICE. INSURANCE. INVESTMENTS.

96099001

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

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

Section 2 Person Insured

Note: Please complete even if the person 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. ☐ Smoker ☐ Non-Smoker†

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

5. Country of Birth: _____

6. Plan(s) insured under:
- ☐ Basic Life Insurance
- ☐ Family Life Insurance
- ☐ Long Term Disability Insurance
- ☐ Office Overhead Expense Insurance

† 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.

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.

DECLARATION AND AUTHORIZATION

Section 3 To Be Read, Signed and Dated By the Applicant (and Person Insured if Other than the Applicant)

I apply to The Manufacturers Life Insurance Company (Manulife Financial) for consideration for AdvantEdge and/or AdvantEdge Special premium rates, or HealthEdge and/or HealthEdge Special premium rates, for the 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 for the insurance to which this application relates. 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 reinstatement date is a risk not covered. I/we understand that the change to AdvantEdge and/or AdvantEdge Special premium rates, or HealthEdge or HealthEdge Special premium rates, if approved by Manulife Financial, will take effect on the date the properly completed application is approved by Manulife Financial. I/we understand that any health information must be accurate as at the date the application is signed.

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 change in insurance premium rates applied for, I, the person 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 agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health 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 participating provincial or territorial dental associations (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 Insured (if other than the Applicant)

_____ Date: Day Month Year Signed at: _____ City/Town Province
Signature of Applicant

QUEBEC RESIDENTS ONLY: If you have chosen to send Section 4 directly to Manulife Financial, please indicate the date you sent Section 4 to Manulife:

Date: Day Month Year

Manulife Financial
For your future™

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

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

DECLARATION OF INSURABILITY

Section 4

In Quebec, please fill out this box if detaching this Declaration of Insurability, Section 4 (see note on last page):

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

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 or 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. Females only

A. Are you currently pregnant? ☐ Yes ☐ No

If "Yes", please provide expected due date:

Day Month Year

B. Have you had any previous complications of pregnancy such as miscarriage, pre-eclampsia, caesarian section, etc.?
☐ Yes ☐ No

15. IF ANY OF QUESTIONS 6 THROUGH 13 ARE ANSWERED "YES", PLEASE 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.

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.

Quebec residents only: When your completed application is returned to CDSPI, SECTION 4 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 SECTION 4 of this application and submitting it directly to Manulife Financial. If you wish, you may complete the entire application and mail SECTION 4 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, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4.

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 SECTION 4 and mailing it directly to Manulife Financial, please write below the name of the person insured, his/her date of birth and the CDA Membership Number of the applicant listed in SECTION 1.

Name of Person 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