Manulife

CDSPI ADVICE. INSURANCE. INVESTMENTS.

APPLICATION

Dental Office Staff Insurance

For assistance in filling out this application, call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416.296.9401, Email: insurance@cdspi.com

Please complete all pertinent questions to avoid processing delays and return to: **CDSPI**,
155 Lesmill Road, Toronto, Ontario M3B 2T8. Fax: 1.866.337.3389 or 416.296.8920

18-

Accessible formats and communication supports are available upon request. Visit **cdspi.com/accessibility** for more information.

You must be a full-time employee under age 65 who works for at least one dentist who is a member of the CDA and/or a participating provincial or territorial dental association to be eligible to apply for or renew this coverage. To be eligible for disability coverage, you must also work an average of at least 18 hours a week. In Quebec, eligibility is limited to employees of CDA members.

INDIVIDUAL INFORMATION

Section 1 Applicant Information

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

Last | First | Middle or Middle Initial

2. Mailing Address:
Check one: ☐ Home ☐ Business

Street and Number | Suite No.

City/Town | Province | Postal Code

3.
Business Telephone | Home Telephone

Mobile Telephone | Fax

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

5. A. Account Number, if known: ☐☐☐☐☐☐

B. Billing Preference (*check one*):
- ☐ Same as current
- ☐ Annually
- ☐ Quarterly
- ☐ Monthly*
- ☐ Pre-authorized Chequing*
- ☐ Pre-authorized 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% processing charge applies to monthly and quarterly payments

6. Language Preference: ☐ English ☐ French

Section 2 Person To Be Insured

Note: Please complete even if the Person To Be Insured is the same as the applicant.

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

Last | First | Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Smoker ☐ Non-Smoker†

4. Date of Birth: ☐☐☐☐☐☐☐☐
D D M M Y Y Y Y

5. Country of Birth: _____

6. A. Occupation (*check one*):
- ☐ Hygienist
- ☐ Certified Dental Assistant
- ☐ Other Employee *(specify below)*:

_____

B. Hours worked per week: Minimum _____ Average _____

7. Name(s) of All Current Employing Dentists:

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

B. _____
- ☐ Member of Provincial/Territorial Dental Association*
- ☐ Member of CDA

C. _____
- ☐ Member of Provincial/Territorial Dental Association*
- ☐ Member of CDA

* Excluding the ACDQ in Quebec.

† **Note:** 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.

Plan Underwritten by The Manufacturers Life Insurance Company.

COVERAGE APPLIED FOR

Section 3 Entry Level Coverage (New Staff)

If you are applying for Entry Level Coverage, skip Sections 4, 5, 6, 10 and 11, and complete Sections 9 and 12 only.

1. A. I would like to receive Entry Level Coverage* which includes $25,000 Basic Life, $200/month Disability, and $50,000 Accidental Death and Dismemberment (AD&D) Insurance. (*check if desired*) ☐

B. Date insured person's employment commenced with employing dentist: D D M M Y Y Y Y

* Employees must apply within three months of becoming a new staff member.

Section 4 Full Coverage – Life Insurance

Complete Sections 8, 9, 10 and 12. If applying for Family Life (Spouse) coverage, also complete Section 7. If applying for Family Life (Dependent Child) coverage, also complete Section 11.

1. Amount of Basic Life Insurance desired at this time ($50,000 minimum, available in units of $10,000):

$ _____

2. Waiver of Premium Option (*for Basic Life coverage – check if desired*) ☐

3. Amount of Family Life Insurance (Spouse) coverage desired at this time (*$50,000 minimum, maximum amount cannot be greater than employee's coverage*):

$ _____

Note: Please ensure that you complete Sections 7 and 10 if applying for Family Life (Spouse) coverage.

4. Waiver of Premium Option (*for Spousal coverage – check if desired*) ☐

5. Family Life Insurance (Dependent Child) coverage (*for Dependent Child coverage – check if desired*) ☐

Name in full of Oldest Dependent Child

_____

Date of Birth: D D M M Y Y Y Y

Note: Please ensure that you complete Section 11 if applying for Family Life (Dependent Child) coverage.

6. Replacement of Other Life Insurance

Will any of the coverage applied for replace any life insurance currently in force (other than through CDSPI)? ☐ Yes ☐ No

If "Yes", please provide details below about the coverage in force:

Company _____

Plan _____

Amount _____

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 5 Full Coverage – Accidental Death and Dismemberment (AD&D) Insurance

1. Amount of AD&D Insurance desired at this time ($50,000 minimum, available in units of $10,000):

$ _____

2. AD&D Family coverage – I would like my AD&D coverage to cover my family. (*check if desired*) ☐

Note: Please ensure that you have completed the spouse information (if applicable) in Section 7 if applying for AD&D family coverage, and question 1 of Section 11 if children are to be covered.

Plan Underwritten by The Manufacturers Life Insurance Company.

Section 6 Full Coverage – Long Term Disability (LTD) Insurance

1. Amount of LTD coverage desired at this time ($500/month minimum, available in units of $100):

$ _____

Options (*check if desired):*

2. Would you like the Five Year Regular Occupation Option? *(Available to applicants under 50 years of age)* ☐

3. Would you like the Residual Disability Option? ☐

4. Would you like the Cost of Living Adjustment Option? ☐

5. **A.** Do you have any pending or existing life, critical illness or disability insurance coverage with CDSPI or any other company (other than coverage you may have through your employer)? ☐ Yes ☐ No

B. If "Yes", please provide details:

Name of Applicant	Company Name	Type of Insurance	Personal or Business	Amount of Coverage ($)	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No

Complete Sections 8, 10 and 12

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

SPOUSE INFORMATION

Section 7 Spouse of Staff Member To Be Insured Under Family Coverage

1. Name (*please print*):

_____
Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Smoker ☐ Non-Smoker†

4. Date of Birth: D D M M Y Y Y Y

5. Country of Birth: _____

6. Occupation: _____

† **Note**: 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.

Complete Sections 8, 9, 10 and 12.

Section 8 Financial Information for Person To Be Insured (and Spouse, if applying for Family Life Coverage)

Please complete Question 1 if you are applying for Full Long Term Disability Coverage.

1. Does your unearned income (investments, interest, pension, etc.) exceed 15% of your total earned income? ☐ Yes ☐ No

If "Yes", please provide the amount of your unearned income for:

Current Year to Date _____ Prior Year _____

Source(s) _____

2. Personal Net Worth (assets less liabilities):

Applicant: $ _____

Spouse: $ _____

3. Applicant Annual Salary $ _____

Spouse Annual Salary $_____

Note: Please submit pages 1, 2 and 3 of your last tax return or your last T4 form if you are applying for more than $3,500/month of total* Long Term Disability coverage.

* Total = All existing and applied for Long Term Disability coverage with all companies, including CDSPI coverage.

Plan Underwritten by The Manufacturers Life Insurance Company.

Section 9 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 in **box A** 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 if making a spouse a revocable beneficiary
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 (child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐
D. AD&D Insurance (insured)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐
E. AD&D Insurance (spouse)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐
F. AD&D Insurance (child)	Primary Beneficiary				☐	☐
	Primary Beneficiary				☐	☐
	Total 100%					
	Contingent Beneficiary				N/A	☐

2. 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.

A. Beneficiary Name: _____

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

C. Trustee Name: _____

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

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

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

Plan Underwritten by The Manufacturers Life Insurance Company.

DECLARATION OF INSURABILITY

Section 10 Life Insurance/Long Term Disability Insurance

For Quebec residents, please fill out this box only if detaching Sections 10 and 11 (see note for Quebec residents at the end of Section 11):

Name of Person To Be Insured: Date of Birth: Application Date:

Last First Middle or Middle Initial D D M M Y Y Y Y D D M M Y Y Y Y

Name of Spouse To Be Insured: Date of Birth: Application Date:

Last First Middle or Middle Initial D D M M Y Y Y Y D D M M Y Y Y Y

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

To be completed by the Person(s) To Be Insured

YOUR PERSONAL INFORMATION

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
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:	☐	☐	☐	☐
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:	☐	☐	☐	☐
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:	☐	☐	☐	☐
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):	☐	☐	☐	☐
4. **Within the next 12 months:** 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:	☐	☐	☐	☐
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:	☐	☐	☐	☐
5. **Within the past 5 years:** 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:	☐	☐	☐	☐
b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details:	☐	☐	☐	☐
c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐	☐	☐

Continued... ▶

Section 10 Life Insurance/Long Term Disability Insurance (cont'd)

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.

YOUR MEDICAL INFORMATION

Physician's name: _____

Physician's address and telephone number: _____

Date, reason and result of last consultation, and if any treatment or medication prescribed: _____

_____

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

Has your weight changed in the past year? ☐ Yes ☐ No If yes: Gained _____ ☐ lb ☐ kg Lost _____ ☐ lb ☐ kg

Reason for change: _____

To be completed by spouse if applying for Family Life Insurance

Spouse Physician's name: _____

Spouse Physician's address and telephone number: _____

Date, reason and result of last consultation, and if any treatment or medication prescribed: _____

_____

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

Has your weight changed in the past year? ☐ Yes ☐ No If yes: Gained _____ ☐ lb ☐ kg Lost _____ ☐ lb ☐ kg

Reason for change: _____

	MEMBER		SPOUSE	
	YES	NO	YES	NO
6. **Have you 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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐	☐	☐
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?	☐	☐	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
m) **Cancer, cysts, lumps, polyps, or tumour**?	☐	☐	☐	☐
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?	☐	☐	☐	☐

Continued... ▶

Section 10 Life Insurance/Long Term Disability Insurance (cont'd)

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
7. **If female**, a) are you currently pregnant?				
If yes, give due date, and the name and address of your obstetrician/gynecologist: _____	☐	☐	☐	☐
b) What was your pre-pregnancy weight? _____ ☐ lb _____ ☐ kg				
c) Have there been any complications with your pregnancy? If yes, provide details: _____	☐	☐	☐	☐
8. **PLEASE SKIP QUESTION 8 IF ONLY APPLYING FOR LIFE INSURANCE.**				
During the past 5 years, have you:	☐	☐	☐	☐
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain, sciatica, or other?	☐	☐	☐	☐
b) Had X-rays (including of the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐	☐	☐	☐
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐	☐	☐	☐
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐	☐	☐
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath or any other health care worker) for any reason including routine or annual physical examinations or checkups?	☐	☐	☐	☐
9. **Within the past 2 years, have you:**				
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐	☐	☐
b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐	☐	☐
c) Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐	☐	☐
d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐	☐	☐

If you answered yes to any of the questions in the section titled Your Medical Information, please provide details in the table below. If more space is required, please attach a separate sheet (dated and signed):

YOUR MEDICAL INFORMATION DETAILS

Question Number & Part	Name of Applicant	Nature of Disorder	Date & Duration	Treatment (if None, state "None") & Current Status*	Attending Physician or Hospital

Note: If you need more space, please use a separate signed and dated sheet of paper, and attach to this form. * Include the results of all physical examinations and checkups

YOUR FAMILY MEDICAL HISTORY

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
10. **Have any of your parents or siblings (brothers or sisters):**				
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐	☐	☐
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?	☐	☐	☐	☐

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

Name of Applicant	Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death (if applicable) and Cause

Plan Underwritten by The Manufacturers Life Insurance Company.

Section 11 Dependent Children

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.

1. Please fill out this question only if applying for Family Life (Dependent Child) or Family AD&D Insurance coverage

Name of Child *(please print)*	Date of Birth (dd/mm/yyyy)	Sex	If Over 21, Full-Time Student?	If "Yes", please list Program end date (Month and Year)
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

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

2. Please fill out this question only if applying for Family Life Insurance (Dependent Child) coverage

A. Complete the table below only if applying for Family Life (Dependent Child) coverage.

Name of Child *(please print)*	Height		Weight	Change in weight in last 12 months	
	m/ft	cm/in	kg/lb	Gain	Loss

B. To the best of your knowledge, do any of your dependent children have any mental or physical impairment or disease or symptoms of ill health, or are any of your dependent children under observation, receiving advice or treatment, or taking medication? ☐ Yes ☐ No

If "Yes", please provide details below.

Name of Child *(please print)*	Date & Duration	Treatment (if None, state "None") & Current Status	Name & Address of Child's Physician

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 10 and 11 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 Sections 10 and 11 of this application and submitting it directly to Manulife. If you wish, you may complete the entire application and mail Sections 10 and 11 only to the following address: ATTN: Consumer 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, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

If you are detaching Sections 10 and 11 and mailing it directly to Manulife, please complete the name of the Person(s) 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.

Name of Person To Be Insured: CDA Membership Number (Applicant): Date of Birth (Person To Be Insured): Date Applicant Signed:

Last First Middle or Middle Initial

D D M M Y Y Y Y D D M M Y Y Y Y

Name of Spouse To Be Insured: CDA Membership Number (Applicant): Date of Birth (Person To Be Insured): Date Applicant Signed:

Last First Middle or Middle Initial

D D M M Y Y Y Y D D M M Y Y Y Y

Plan Underwritten by The Manufacturers Life Insurance Company.

DECLARATION AND AUTHORIZATION

Section 12 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 certificate booklet containing a detailed description of coverage, conditions, limitations and exclusions.

I/We apply to The Manufacturers Life Insurance Company (Manulife) for the insurance indicated above under the group policy issued 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 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 or increased coverage is limited to Canadian citizens or permanent residents of Canada who are employees of members of the CDA or participating provincial or territorial dental associations (in Quebec, only employees of CDA members are eligible).

_____ Signature of Person To Be Insured (if other than the Applicant)	Date: D D M M Y Y Y Y	Signed at: _____ City/Town	_____ Province/Territory
_____ Signature of Applicant	Date: D D M M Y Y Y Y	Signed at: _____ City/Town	_____ Province/Territory
_____ Spouse's Signature (if Family Insurance is applied for)	Date: D D M M Y Y Y Y	Signed at: _____ City/Town	_____ Province/Territory
_____ Signature of Child (if Family Insurance is applied for and child is 18 years of age or older)	Date: D D M M Y Y Y Y	Signed at: _____ City/Town	_____ Province/Territory

QUEBEC RESIDENTS ONLY: If you have chosen to send Sections 10 or 11 directly to Manulife, please indicate the date you sent Sections 10 or 11 to Manulife:

Date: D D M M Y Y Y Y

Manulife

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.

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: The Chief Privacy Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

Plan Underwritten by The Manufacturers Life Insurance Company.

BLANK PAGE

NOTICE ON PRIVACY AND CONFIDENTIALITY – **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.

Plan Underwritten by The Manufacturers Life Insurance Company.

BLANK PAGE

BLANK PAGE