APPLICATION

Dental Office Staff Insurance

ADVICE. INSURANCE. INVESTMENTS.

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401, E-mail: insurance@cdspi.com

96099001

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

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 this coverage. To be eligible for disability coverage you must work an average of at least 18 hours a week. In Quebec, eligibility is limited to employees of CDA members. If making changes to existing coverage, there are no membership eligibility requirements for the employing dentist.

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.
E-mail address (*please include to expedite the application process*)

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

5. B. Payment Frequency (*Choose one*):

☐ Same as current
(Only applies if you are an existing client paying premiums)
☐ Annually
☐ Quarterly*
☐ Monthly*
(If paying monthly, you must select Automatic Payments under the Payment Method section below)

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

5. C. Payment Method (*Choose one*):

☐ Invoice (Will be mailed to your address on file for payment.)
☐ Automatic Payments
☐ Pre-authorized Chequing Plan (PAC) -
Please complete a Pre-Authorized Chequing Plan Form
☐ VISA/MasterCard –
CDSPI will contact you to obtain credit card details upon receipt of your application.

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: ⌊ | | | | | | | | ⌋
Day Month Year

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

† 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.

* Excluding the ACDQ in Quebec.

COVERAGE APPLIED FOR

Section 3 Entry Level Coverage (New Staff)

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*) ☐

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

B. Date insured person's employment commenced with employing dentist: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋
Day Month Year

If you are applying for Entry Level Coverage, skip Sections 4, 5 and 6 and complete Sections 9 and 10 only. You do not need to complete Sections 11, 12 or 13.

Section 4 Full Coverage – Life Insurance

1. Amount of Basic Life Insurance desired at this time ($50,000 minimum)

$ _____

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 Section 7 and 12, 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: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋
Day Month Year

Note: Please ensure that you complete Section 13, 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? ☐ Yes ☐ No

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

Company _____

Plan _____

Amount _____

Complete Sections 8, 9, 10 and 11. If applying for Family Life (Spouse) coverage also complete Sections 7 and 12. If applying for Family Life (Dependent Child) coverage also complete Section 13.

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

1. Amount of AD&D Insurance desired at this time ($50,000 minimum)

$ _____

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 13 if children are to be covered.

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

1. Amount of LTD coverage desired at this time ($500/month minimum)

$ _____

2. 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* coverage.

** Total = All existing and applied for coverage with all companies, including Canadian Dentists' Insurance Program coverage*

Options (*check if desired*)

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

4. Would you like the Residual Disability Option? ☐

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

6. Do you currently have in force or have you concurrently applied for any disability income coverage outside of the Canadian Dentists' Insurance Program? ☐ Yes ☐ No

If "Yes", please state:

Name of Company _____

Amount $ _____

Benefit Period _____

Elimination Period _____

Are the benefits taxable? ☐ Yes ☐ No

Will you be replacing the above disability coverage? ☐ Yes ☐ No

Complete Sections 8, 10 and 11.

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: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋
Day Month Year

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 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) _____

Please complete Question 2 if you are applying for more than $250,000 of new life coverage:

2. Personal Net Worth (assets less liabilities):

Applicant: $ _____

Spouse: $ _____

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 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 (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 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, following the person to be insured's death.

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: _____

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

DECLARATION AND AUTHORIZATION

Section 10 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 and limitations.

I apply to The Manufacturers Life Insurance Company (Manulife Financial) for the insurance indicated above under the group policy issued 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 (if applying for Full Coverage) 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, 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 insurance will take effect on the date the properly completed application is approved by Manulife Financial, subject to the person to be insured being actively at work on that date and to 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 at 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 and/or health.

I (the applicant) designate the individual(s) named as beneficiary in this application to receive any death benefits payable under the group policy 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, 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 (including my accountant) that has any records or knowledge of me, my finances, 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 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 is limited to Canadian residents who are under age 65 and full-time office employees of a dentist who is a member of the CDA or a participating provincial or territorial dental association. To be eligible for disability coverage employees must work an average of at least 18 hours a week.

_____ 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
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)

QUEBEC RESIDENTS ONLY: If you have chosen to send Section 11, 12 and/or 13 directly to Manulife Financial, please indicate the date you sent the Section(s) to Manulife:

Date: Day Month Year

DECLARATION OF INSURABILITY

Section 11 Life Insurance/Long Term Disability Insurance

In Quebec, please fill out this box if detaching Declaration of Insurability, Sections 11, 12 and 13 (see note on last page):

Name of Person To Be Insured: _____ Employer's CDA Membership Number: _____ Date of Birth: Day Month Year Application Date: Day Month Year

Last First Middle or Middle Initial

Name of Applicant: _____ Employer's CDA Membership Number: _____ Date of Birth: Day Month Year Application Date: Day Month Year

Last First Middle or Middle Initial

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. Within the past 10 years have you ever had an application for Life or Disability Income Insurance declined, postponed, rated, or modified in any way?

☐ Yes ☐ No

B. Have you ever made a claim, received benefits, pension or compensation or have you ever been absent from work for more than one week or been disabled due to sickness or accident?

☐ Yes ☐ No

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

_____

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:

_____

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 ever declared, or are you contemplating bankruptcy?

☐ Yes ☐ No

If "Yes", please give details and date of discharge:

_____

7. In the past 5 years have you 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

8. 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

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

10.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 consumed substantially more alcohol than as outlined above?
☐ Yes ☐ No

If "Yes", please provide details:

_____

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

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

E. Have you ever 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:

_____

F. 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: _____

11. 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

12.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

13. IF ANY OF QUESTIONS 7 THROUGH 11 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.

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 12 Family Life Insurance – Spouse

To be completed by spouse if applying for Family Life Insurance.

1. A. Name, Address and Phone Number of your 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. Are you in good health and free of any symptoms of illness or disease? If "No", please provide details:
☐ Yes ☐ No

_____

4. If your answer to any of the questions in Section 11, questions 2 to 4 is "Yes", please provide details:

_____

5. Have you ever had any of the conditions listed in questions 7 to 11 of Section 11? If "Yes", please provide details 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.

NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person to be insured**

Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services, and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services, and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside of Canada, and subject to the laws of those foreign jurisdictions. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, Ontario N2J 4C6.

CDSPI and CDSPI Advisory Services Inc. collect, use and disclose your personal information on this application for purposes that include: determining your eligibility for our plans; administering and providing insurance and financial services to you; underwriting; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; marketing and to advise you of other related products and services. We limit access to your personal information in our files to our employees, authorized agents and third-party service providers, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You may request to review the personal information your file contains and make corrections by sending a written request to: CDSPI, Attn: The Chief Privacy Officer, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4. To find out more about our privacy practices, visit www.cdspi.com/privacy.

Section 13 Dependent Children

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

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

Name of Proposed Insured (Please print)	Date of Birth (Day/Month/Year)	Sex	If Over 21, Full-Time Student?	If "Yes", please list Program end date (Month and Year)	Place of Birth	Height		Weight	Change in weight in last 12 months	
						m/ft	cm/in	kg/lb	Gain	Loss
			☐ 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

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 Proposed Insured (Please print)	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.

Quebec residents only: When your completed application is returned to CDSPI, SECTIONS 11, 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 11, 12 & 13 of this application and submitting them directly to Manulife Financial. If you wish, you may complete the entire application and mail SECTIONS 11, 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, 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 SECTIONS 11, 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's employer.

Name of Person to be Insured: _____ Employer's CDA Membership Number: _____ Date of Birth: _____ Application Date: _____

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

22-31 11/22

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