APPLICATION

Term 100 Life 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

Membership Requirements for New Coverage: Licensed dentists must be members of the CDA or a participating provincial or territorial dental association to be eligible to apply for this coverage.

If a spouse is applying, the dentist must meet eligibility requirements as stated above.

Students do not have to be members.

There are no Membership Requirements if converting your CDSPI Basic Life or CDSPI Family Life Coverage to Term 100 Coverage.

Membership Requirements for Existing Coverage: If you are making a change to an existing policy, there are no membership eligibility requirements.

Section 1 Applicant Information

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

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

2. Individuals only: ☐ Male ☐ Female

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

Street and Number Suite No.

City/Town Province Postal Code

4.

Business Telephone Home Telephone

Mobile Telephone Fax

5.

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

6. A. Account Number, if known: ⌊_⌊_⌊_⌊_⌊_⌊_⌋

6. 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)

* Processing charges of 3.98% and 3.73% apply to monthly and quarterly payments respectively.

6. 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.

7. 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: ☐ 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. Status of Applicant (*check one*):

A. ☐ Licensed Dentist who is a member of:
☐ A participating Provincial/Territorial Dental Association
☐ CDA

Provincial/CDA License Number **(mandatory)**:

_____

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. ☐ Spouse of Eligible Dentist

Name of Licensed Dentist who is a member of a participating Provincial/Territorial Dental Association or the CDA:

_____

Dentist's Provincial/CDA License Number (mandatory):

_____

E. ☐ Other (please specify): _____

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

† Note: You are considered a non-smoker if you have not used any form of tobacco or tobacco cessation products in the 12 months prior to signing this application. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

Section 3 Financial Information of Person To Be Insured

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

$ _____

2. Personal Net Worth (assets less liabilities):

$ _____

COVERAGE APPLIED FOR

Section 4 Term 100 Life Insurance

Available to applicants 18 to 70 years of age inclusive

1. Amount of insurance applied for <u>at this time</u> **(do not include existing coverage)**:

$ _____

2. Type of Plan (*check one*):

☐ Individual
☐ Joint First to Die – Premiums until first death
☐ Joint Last to Die (Survivor) – Premiums until second death

3. For either of the Joint plans please indicate name and date of birth of additional life to be insured as shown on the second application, and submit both applications together:

A. Name (*please print*):

_____
Last First Middle or Initial

B. Date of Birth: ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋
Day Month Year

4. Options

A. Would you like the Waiver of Premium Option? ☐ Yes ☐ No
(*Available to applicants 18 to 54 years of age inclusive*)

B. Would you like the Indexing Option? ☐ Yes ☐ No
(*Available to applicants 18 to 64 years of age inclusive*)

Section 5 Replacement of Other Life Insurance

To be completed by the person to be insured

1. A. Do you currently have any pending or existing life insurance coverage, other than through the Canadian Dentists' Insurance Program?
☐ Yes ☐ No

B. If "Yes", please provide details:

Insuring Company	Amount of Coverage ($)	Is coverage pending or existing? Choose one box below.	Do you intend to replace this coverage?
		☐ Pending ☐ Existing	☐ Yes ☐ No
		☐ Pending ☐ Existing	☐ Yes ☐ No
		☐ Pending ☐ Existing	☐ Yes ☐ No

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

	Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
			Total 100%		
Contingent Beneficiary				N/A	☐
Contingent Beneficiary				N/A	☐
			Total 100%		

Note: If you are selecting joint insurance, contact CDSPI Advisory Services Inc. about beneficiary designation.

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. Minor Beneficiary Name: _____

B. Trustee Name: _____

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

Note: If you need more space, complete a separate signed and dated sheet and attach to this form.

DECLARATION AND AUTHORIZATION

Section 7 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 in Section 4 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, 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 last reinstatement date is a risk not covered. I/we understand that insurance will take effect on the date the properly completed application is approved by Manulife Financial subject to payment of the first premium within 30 days of issuance of a premium invoice. I/we understand that any health information must be accurate as of the date the application is signed.

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

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

I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality and the Notice on Exchange of Information.

Relative to the insurance applied for, I, the person to be insured, authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB Group, Inc., the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health 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 Certificate of Insurance issued as a result of this application. I/we understand that this 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 citizens or permanent residents of Canada who are members of the CDA or a participating provincial or territorial dental association (in Quebec, only CDA members are eligible) , the spouse and children of an eligible dentist, the spouse of an eligible child, full-time undergraduate or graduate students in a Canadian school or faculty of dentistry, full-time employees of a participating Canadian dental association or organization, and non-members converting their existing CDSPI Basic Life or CDSPI Family Life coverage to Term 100 coverage.

_____ 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

QUEBEC RESIDENTS ONLY: If you have chosen to send Section 8 directly to Manulife Financial, please indicate the date you sent Section 8 to Manulife:

Date: Day Month Year

DECLARATION OF INSURABILITY

Section 8 Term 100 Life Insurance

In Quebec, please fill out this box if detaching this Declaration of Insurability, Section 8 (see note on last page):

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

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

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

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

IMPORTANT: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests.*

***Genetic tests means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.**

To be completed by the Person To Be Insured

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

_____

_____

B. Date and reason last consulted:

Date (dd/mm/yy): _____

Reason: _____

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

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

_____

_____

E. Results and current status:

_____

_____

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

B. Are you currently receiving disability benefits or have you ever made a claim, received benefits, pension or compensation due to sickness or illness?
☐ 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 five years, have you piloted an aircraft or do you intend to do so?
☐ Yes ☐ No

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

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

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

_____

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

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

_____

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

B. Weight: _____ kg or _____ lb

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

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

☐ Loss ☐ Gain

Reason: _____

6. Have you during the past 5 years:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

Amount	Wine	Beer	Liquor
Daily			
Weekly			
Monthly			

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

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

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

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

_____

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

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

_____

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

13. 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, cesarian section, etc.?
☐ Yes ☐ No

14.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

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.

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.

Quebec residents only: When your completed application is returned to CDSPI, SECTION 8 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 8 of this application and submitting it directly to Manulife Financial. If you wish, you may complete the entire application and mail SECTION 8 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 8 and mailing it directly to Manulife Financial, please write below the name of the person to be insured, his/her date of birth and the CDA Membership Number of the applicant listed in SECTION 1.

Name of Person To Be Insured:			CDA Membership Number:	Date of Birth:	Application Date:
Last	First	Middle or Middle Initial		Day Month Year	Day Month Year
Name of Applicant:			CDA Membership Number:	Date of Birth:	Application Date:
Last	First	Middle or Middle Initial		Day Month Year	Day Month Year

22-32 11/22

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

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