CDSPI ADVICE. INSURANCE. INVESTMENTS.

Provided by Manulife

APPLICATION FOR
Accidental Death and Dismemberment Insurance

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.

Students do not have to be members.

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

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, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4. Fax: 1.866.337.3389 or 416.296.8920

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

SECTION 1 Applicant Information

A. Name (please print)

Check one ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Corporation

Last Name (Or name of partnership or corporation)

First Name | Initial

B. Individuals only ☐ Male ☐ Female

C. Mailing Address Check one ☐ Home ☐ Business

Street and Number | Apt/Suite

City/Town | Province | Postal Code

Home Phone | Business Phone

Cell Phone | Fax

Email Address (Not mandatory but may expedite application process)

D. Account Number (if known)

Payment Frequency (Choose One):

☐ Same as current
(Only applies if you are an existing client paying premiums)

☐ Annual

☐ 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.

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 for credit card details upon receipt of your application

E. Language Preference ☐ English ☐ French

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

A. Type of coverage required ☐ Single ☐ Family

B. Amount of coverage applied for at this time (do not include existing coverage) $ _____
(Minimum coverage is $50,000. Please use $10,000 increments)

PLAN UNDERWRITTEN BY THE MANUFACTURERS LIFE INSURANCE COMPANY

SECTION 3 Person To Be Insured - Must Complete For Single and Family Coverage

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

A. Name (please print)

Check one ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name (or name of partnership or corporation)

First Name | Initial

B. ☐ Male ☐ Female

C. Date of Birth | | | (DD/MM/YYYY)

D. Status (check one)

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

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

Date of Graduation | | | (DD/MM/YYYY)

Name of University or Dental Faculty

Dental Specialty

2. ☐ Dental Student

Name of University or Dental Faculty

3. ☐ Employee of Dental Association

Name of Association

4. ☐ Other (please specify) _____

SECTION 4 Spouse To Be Insured Under Family Coverage

A. Name (please print)

Check one ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. Date of Birth | | | (DD/MM/YYYY)

SECTION 5 Dependent Children To Be Insured Under Family Coverage

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

First Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Married ☐ Unmarried

D. Date of Birth (DD/MM/YYYY)

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

If "Yes", Program End Date (DD/MM/YYYY)

Second Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Married ☐ Unmarried

D. Date of Birth (DD/MM/YYYY)

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

If "Yes", Program End Date (DD/MM/YYYY)

Third Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Married ☐ Unmarried

D. Date of Birth (DD/MM/YYYY)

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

If "Yes", Program End Date (DD/MM/YYYY)

Fourth Child

A. Name (please print)

Last Name

First Name | Initial

B. ☐ Male ☐ Female

C. ☐ Married ☐ Unmarried

D. Date of Birth (DD/MM/YYYY)

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

If "Yes", Program End Date (DD/MM/YYYY)

NOTE: If you need more space for additional children, use a separate signed and dated sheet of paper and attach it.

SECTION 6 Beneficiaries

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

NOTE: If purchasing additional coverage, this beneficiary designation relates only to the additional coverage being purchased. Beneficiary designations for coverage already issued will remain in force as is.

If a beneficiary is designated as revocable, you (the Owner) 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 (the Owner) 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 (the Owner) specify** that the designation is revocable by checking the box in the Quebec column below.

If you (the Owner) 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 (the Owner) 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 & 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
AD&D INSURANCE (INSURED)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐
AD&D INSURANCE (SPOUSE)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐
AD&D INSURANCE (CHILD)	PRIMARY BENEFICIARY				☐	☐
	PRIMARY BENEFICIARY				☐	☐
	TOTAL 100%					
	CONTINGENT BENEFICIARY				N/A	☐

B. 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.

Beneficiary Name

Trustee Name

Relationship of Trustee to Person To Be Insured

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

C. **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.

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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.

SECTION 7 Declaration and Authorization (To be read, signed and dated by applicant/Person To Be Insured)

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

If this application is approved for coverage the applicant will receive a certificate booklet containing a detailed description of the coverage, conditions, limitations and exclusions.

I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality set out in this Application. A photocopy or facsimile of this authorization shall be as valid as the original.

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), full-time undergraduate or graduate students in a Canadian school or faculty of dentistry or full-time employees of a participating Canadian dental association or organization.

QUEBEC RESIDENTS 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.

Signature of Person To Be Insured (if other than the Applicant)	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Applicant	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Spouse (if Family Insurance is applied for)	Date (DD/MM/YYYY)	Signed at: City	Province
Signature of Child (if Family Insurance is applied for and child is 18 years of age or older)	Date (DD/MM/YYYY)	Signed at: City	Province

Manulife

NOTICE ON EXCHANGE OF INFORMATION — 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.