CDSPI ADVICE. INSURANCE. INVESTMENTS.

Provided by Manulife AVIVA

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No-Cost Optional Graduate Package Form for Students

Life, Accidental Death & Dismemberment (AD&D), DisabilityGuard™ and TripleGuard™ Insurance

IMPORTANT NOTES:

- You must be age 18 to 39 on the date this Application Form is received by CDSPI and meet other eligibility criteria to receive coverage. If you are age 40 to 64, you must complete a different application. Contact CDSPI for details.
- You must qualify medically to obtain coverage from Manulife. Please answer all questions in Section 2, Declaration of Insurability.
- In order to apply for the Optional Graduate Package, you must be enrolled in the Undergraduate Package. If you are not already enrolled in the Undergraduate Package, CDSPI will automatically enrol you, provided this completed application is received prior to your graduation date.
- If your application is approved, coverage will be effective** at graduation or the date the application is approved, if later. You will pay absolutely no premiums for this coverage up to December 31st of your graduation year. Effective January 1st after your graduation year, you will receive a 50 per cent savings on regular premiums for the Life, AD&D and TripleGuard™ Insurance in the Optional Graduate Package for three calendar years following graduation and a 15% **lifetime** savings on regular premium rates for DisabilityGuard ™ Insurance for the life of the policy. DisabilityGuard™ premium rates are guaranteed to age 65. **Provided that you are not on claim or satisfying an elimination period.

TripleGuard™ is underwritten by Aviva Insurance Company of Canada.

SECTION 1 Applicant Information

A. Are you a full-time dental student? ☐ Yes ☐ No

B. Are you a Canadian citizen or permanent resident of Canada? ☐ Yes ☐ No

NOTE: If you answered "No" to questions A. or B. **you are not eligible for coverage.**

You are eligible for coverage if you are a dental student (or a dentist who was a student and has graduated this calendar year). "Student" means a full-time dental student enrolled in an accredited Canadian school or faculty of dentistry who is a Canadian citizen or a permanent resident of Canada.

C. Person to be Insured

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Male ☐ Female

Last Name

First Name　　Initial

Date of Birth (DD/MM/YYYY)　　Place of Birth

D. I am a ☐ Smoker ☐ Non-Smoker

The definition of a non-smoker is that you have not used any tobacco products (i.e. cigarettes, pipe tobacco, chewing tobacco, tobacco cessation products, etc.) for 12 months prior to signing this form.

E. University Information

Name of University

Year of Graduation

Are you enrolled in the qualifying program for foreign-trained dentists? ☐ Yes ☐ No

F. CDSPI Account Number (if known)

G. Address

Current Mailing Address　　Apt/Suite

City　　Province　　Postal Code

Phone　　Cell Phone

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

Other Fixed Address if applicable　　Apt/Suite

City　　Province　　Postal Code

Phone

SECTION 1 Applicant Information (continued)

H. Language Preference ☐ English ☐ French

I. Beneficiary Designation

I designate the person named below as my beneficiary to receive any money payable under the Life and AD&D Insurance upon my death.
I understand that my beneficiary appointment is revocable. NOTE: If you wish to make a beneficiary designation irrevocable, please contact CDSPI.
If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Last Name | First Name | Initial

Beneficiary's relationship to the person to be insured

QUEBEC RESIDENTS ONLY:

If I designate my legal spouse (married or civil union spouse) as the beneficiary, this designation is automatically irrevocable* unless I check this box: ☐ **Revocable**

*An irrevocable designation means you may not alter or revoke the designation without the beneficiary's written consent.

SECTION 2 Declaration of Insurability

QUEBEC RESIDENTS ONLY: When your completed Enrolment and Application Form is returned to CDSPI, Section 2 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 Section 2 of this form and submitting it directly to Manulife. If you wish, you may complete the entire Enrolment and Application Form and mail Section 2 only to the following address: **ATT: Affinity Markets CDSPI 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, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4.**

Please print your name, date of birth and account number below if you are detaching Section 2 and mailing it directly to Manulife.

Last Name

First Name   Initial

Date of Birth (DD/MM/YYYY) ☐

Account Number (if known) ☐

Name of University

Year of Graduation ☐

A. Personal Information

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. ☐ Yes ☐ No

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. ☐ Yes ☐ No

   b) Within the past 2 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. ☐ Yes ☐ No

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). ☐ Yes ☐ No

Within the next 12 months:

4. a) Any expectation to travel outside of Canada and the United States of America? If yes, give details, including where, when, why and for how long. ☐ Yes ☐ No

   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. ☐ Yes ☐ No

Within the past 5 years:

5. 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 or alcohol type(s) and date(s) last used. ☐ Yes ☐ No

   b) Been convicted of a criminal offence or are you currently charged with one? If yes, please provide details. ☐ Yes ☐ No

   c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details, including date of discharge. ☐ Yes ☐ No

If you answered yes to any part(s) of questions 1 to 5, please provide details below:

QUESTION NO. AND PART	APPLICABLE DATE (DD/MM/YYYY)	ALL APPLICABLE DETAILS

SECTION 2 Declaration of Insurability (continued)

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

B. Family Medical History

Have any of your parents or siblings (brothers or sisters):

1. Been diagnosed prior to age 60 with heart disease, stroke or cancer? ☐ Yes ☐ No

2. 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? ☐ Yes ☐ No

If you answered yes to any part(s) of questions 1 or 2, please provide details below:

FAMILY MEMBER	CONDITION (if cancer, specify type)	AGE AT ONSET	AGE AT DEATH AND CAUSE (if applicable)

C. Medical Information

General

Name of Physician

Phone

Address | Apt/Suite

City | Province | Postal Code

Height ______ ft & in/cm Weight ______ lb/kg

Has your weight changed by more than 10lbs (4.5kg) in the past 12 months?
☐ Yes ☐ No

If yes, provide reason for change below:

☐ Gained ______ lb/kg ☐ Lost ______ lb/kg

Please provide details below of last consultation. Include date, reason, result and any treatment or medication prescribed:

D. Health Conditions, Disorders and Treatments

NOTE: If you answer Yes to any of the following questions, you must provide further details in the table following, titled "Medical Information Details".

1. 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 angio plasty, 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

e) **Your breast,** such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other? ☐ Yes ☐ No

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? ☐ Yes ☐ No

g) **Your eyes or ears,** such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other? ☐ Yes ☐ No

h) **Your mental health,** such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other? ☐ Yes ☐ No

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? ☐ Yes ☐ No

j) **Cancer, cysts, lumps, polyps, or tumour?** ☐ Yes ☐ No

k) **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? ☐ Yes ☐ No

l) **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? ☐ Yes ☐ No

m) **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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

o) Have you been successfully vaccinated against hepatitis B? If no, provide details: ☐ Yes ☐ No

If yes, in what year? ____

p) Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, indicate weekly quantity and type:

Beer ______ bottle(s) per week Wine ______ glasses(s) per week

Liquor ______ oz./ml per week

2. If you are a female,

a) Are you currently pregnant? ☐ Yes ☐ No

Due Date ____ (DD/MM/YYYY)

b) What was your pre-pregnancy weight? ______ lb/kg

c) Have there been any complications? ☐ Yes ☐ No
If yes, provide details:

Name of Obstetrician/Gynecologist

Phone

Address Apt/Suite

City Province Postal Code

D. Health Conditions, Disorders and Treatments (continued)

3. 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? ☐ Yes ☐ No

b) Had X-rays (including the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test? ☐ Yes ☐ No

c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed? ☐ Yes ☐ No

d) Been hospitalized or been medically disabled for more than two consecutive weeks? ☐ Yes ☐ No

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 check-ups? ☐ Yes ☐ No

4. During the past 2 years, have you:

a) Had an abnormal mammogram, PSA or any other test or investigation? ☐ Yes ☐ No

b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)? ☐ Yes ☐ No

c) Been advised to undergo further investigation, see another doctor or have surgery? ☐ Yes ☐ No

d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness? ☐ Yes ☐ No

MEDICAL INFORMATION DETAILS

If you answered yes to any part(s) of questions 1 to 4 above, please answer in the space provided or give details below.

QUESTION NO. AND PART	APPLICABLE DATE (DD/MM/YYYY)	ALL APPLICABLE DETAILS (Include name and address of physician/hospital, if any, and also all information as to the nature of the illness or injury, symptoms, number of attacks, duration, treatment and results)

SECTION 2 Declaration of Insurability (continued)

QUEBEC RESIDENTS ONLY:
Please print your name, date of birth and account number below if you are detaching Section 2 and mailing it directly to Manulife.

Last Name ______ First Name ______ Initial ______ Date of Birth (DD/MM/YYYY) ______

Account Number (if known) ______ Name of University ______ Year of Graduation ______

IMPORTANT: Please note that the insurer may request a medical examination, urinalysis or tests such as a general blood profile, including blood test for HIV/AIDS, 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 3 Declaration and Authorization (To be read and signed by applicant/person to be insured)

I apply to The Manufacturers Life Insurance Company (Manulife) for insurance under the group policies, Life, Accidental Death & Dismemberment, and Disability, and to Aviva Insurance Company of Canada for TripleGuard™ insurance, issued in connection with CDSPI.

I acknowledge receipt of and confirm my agreement with Manulife's Notice on Privacy and Confidentiality, the Notice on Exchange of Information, Aviva's Privacy Notice and CDSPI's Privacy Notice.

I, the undersigned, declare that the statements contained in this application including, if applicable, the statements in Section 2, Declaration of Insurability, are true and complete and, together with any other forms that may be signed by me in connection with this application, form the basis for any policy or certificate issued under the group policies.

I understand that any material misrepresentation, including misstatement of smoker status, shall render any insurance issued pursuant to this application voidable at the instance of the insurer. I understand that if I am required to provide any health information that such information must be accurate as of the date the Declaration of Insurability is signed.

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 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 or its reinsurers any such information, to the extent necessary for the purposes of this application and contract and in the event of any subsequent claim. I authorize Manulife to consult its existing files for these purposes. A photocopy or facsimile of this authorization shall be as valid as the original. I declare that I 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 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.

I understand that for the accidental death and dismemberment and long term disability benefits there are limitations and exclusions that apply. For life insurance, death resulting from suicide within 2 years of the effective date or any reinstatement date is not covered.

This application must be received by CDSPI by December 31st of my graduation year and within 30 days of the signature date below. To apply for the Optional Graduate Package, I must obtain the Undergraduate Package by my graduation date. I understand that my coverage under the Optional Graduate Package does not take effect unless my application is approved by Manulife and such coverage shall not take effect until my graduation date or the date my completed application is approved by Manulife, whichever is later.

Signature of Applicant ______ Date (DD/MM/YYYY) ______

Signed at: City ______ Province ______

QUEBEC PARTICIPANTS ONLY
If you have chosen to send Section 2 directly to Manulife, please indicate the date you sent Section 2 to Manulife: ______ Date (DD/MM/YYYY)

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.

LIFE, AD&D AND DISABILITYGUARD™ INSURANCE ARE UNDERWRITTEN BY THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE).

Manulife has the authority to grant or refuse insurance coverage based on health considerations. Precise details, terms, conditions and exclusions are set out in the insurance contracts for these plans. Manulife, Manulife & Stylized M Design, and Stylized M Design are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under license. © 2020 The Manufacturers Life Insurance Company. All rights reserved. Manulife, P.O. Box 670, Stn Waterloo, ON N2J 4B8

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. You can reach the MIB's information office by writing to **330 University Avenue, Suite 501, Toronto, ON M5G 1R7**, calling **416.597.0590** or emailing **canada_disclosure@mib.com.**

Manulife's Notice on Privacy and Confidentiality:

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

Identifying information such as your name, address, telephone number(s), email address, date of birth, or driver's licence
A personal investigation, financial information, credit bureau report and/or a consumer report from any other organization, person or source that has any information or records about you
Information about how you use our products and services, and information about your preferences, demographics and interests
Other personal information we may require to administer our business relationship with you
We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

Your completed applications and forms
Other interactions between you and the Company
Other sources, such as:Your advisor or authorized representative(s)
Third parties with whom we deal in issuing and administering your policy now, and in the future
Public sources, such as government agencies and internet sites

What do we use your personal information for?

We will use your personal information to:

Help us properly administer the products and services that we provide and to manage our relationship with you
Confirm your identity and the accuracy of the information you provide
Evaluate your application, and issue and administer the rights under the policy
Comply with legal and regulatory requirements
Understand more about you and how you like to do business with us
Analyze data to help us understand our customers better so we can improve the products and services we provide
Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
Authorized employees, agents and representatives
Any person or organization to whom you gave consent
People who are legally authorized to view your personal information
Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
Your medical doctor
Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.
Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.
The personal information you provided in this application:
will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:

the time period required by law and by guidelines set for the financial services industry, and
the time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-877-261-8222, or write to the Privacy Officer at the address below.

Accuracy and Access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
P.O. Box 1602
500 King Street North
Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

NOTICE ON EXCHANGE OF INFORMATION — MUST BE DETACHED, READ AND RETAINED BY THE PERSON TO BE INSURED *(continued...)*

- **Aviva's Privacy Notice:** Aviva Insurance Company of Canada is committed to protecting your personal information and using or disclosing it only for the purposes for which it is collected. For more information about how Aviva uses and protects your personal information, please refer to Aviva's privacy statement at www.avivacanada.com. You may request to review and make corrections to the personal information in the insurer's file by writing to Aviva Canada Inc., Attention: Privacy Officer, 10 Aviva Way, Suite 100, Markham, Ontario, L6G 0G1, or sending an email to CAPrivacyOfficer@avivacanada.com.
- **CDSPI's Privacy Notice:** 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.

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