Manulife

CDSPI ADVICE. INSURANCE. INVESTMENTS.

APPLICATION

To Convert Basic Life Insurance and/or Family Life Insurance to Term 100 Life Insurance

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

Please complete all pertinent questions to avoid processing delays and return to: **CDSPI**,
2005 Sheppard Ave East, Suite 500, Toronto, Ontario 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.

INDIVIDUAL INFORMATION

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. Language Preference: ☒ English ☐ French

7. A. Account Number (if known): _____

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.

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.

Continued…▶

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. STATUS *(check one)*:

A. ☐ Dentist
☐ Member of Provincial/Territorial Dental Association*
☐ Member of CDA
* Excluding the ACDQ in Quebec.
Date of Graduation: | | | | | | | | |
Day Month Year
Name of University or Dental Faculty: _____
Dental Specialty: _____

B. ☐ Dental Student
Name of University or Dental Faculty: _____

C. ☐ Non-dependent Adult Child of Eligible Dental Association Member Dentist
Name of Dentist: _____

D. ☐ Spouse of Non-Dependent Adult Child of Eligible Dental Association Member Dentist
Name of Dentist: _____

E. ☐ Employee of Dental Association
Name of Association: _____

F. ☐ Spouse of Eligible Dental Association Member Dentist
Name of Dentist: _____

G. ☐ Other (please specify): _____

6. 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.

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COVERAGE APPLIED FOR

Section 3 Coverage Being Converted

You may convert up to the amount of Basic Life or Family Life coverage you have in force, but not beyond the plan maximum shown in Question 3.

1. Are the premiums for the life insurance plan being converted currently being waived ? ☐ Yes ☐ No

If "Yes", you are not eligible to convert your coverage at this time. Please contact CDSPI Advisory Services Inc. for more information.

2. Insurance coverage to be converted to Term 100 Life Insurance (*check one*):

- ☐ Basic Life Insurance
- ☐ Spouse Family Life Insurance
- ☐ Adult Child Family Life Insurance
- ☐ Spouse of Adult Child Family Life Insurance

3. Amount of coverage to be converted to Term 100 Life Insurance (Minimum: $50,000; Plan Maximum: $1 million, including existing coverage)

Coverage Amount: $ _____

AND

Policy Number(s): _____

_____

_____

OR

(*check if desired*) ☐ All Policies

4. Waiver of Premium Option

If your coverage to be converted includes the Waiver of Premium Option, do you wish to continue that option on your Term 100 coverage? ☐ Yes ☐ No

Section 4 Beneficiaries

The beneficiary for your converted coverage will be the beneficiary on your existing coverage (and your contingent beneficiary). To change the beneficiary or contingent beneficiary, please contact CDSPI Advisory Services Inc. to obtain a Beneficiary Designation form. Your right to alter the interest of any beneficiary or contingent beneficiary is subject to any applicable law.

DECLARATION AND AUTHORIZATION

Section 5 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) for insurance indicated above under the group policy issued in connection with CDSPI.

I/We, the undersigned, declare that the statements contained in this application 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 pursuant to this application. 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 of the coverage being converted is a risk not covered. I/We understand that insurance will take effect on the date the properly completed application is approved by Manulife, subject to payment of the first premium within 30 days of issuance of a premium invoice. I/We understand that the insurance on a person for whom premiums are being waived, is not eligible for conversion of coverage.

If the applicant is other than myself, I (the Person To Be Insured) consent to the issuance of insurance on my life.
I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality.
A photocopy or facsimile of this authorization shall be as valid as the original.

_____ Date: | | | | | | | | | Signed at: _____
Signature of Person To Be Insured (if other than the Applicant) Day Month Year City/Town Province

_____ Date: | | | | | | | | | Signed at: _____
Signature of Applicant Day Month Year City/Town Province

Additional Consents

The undersigned irrevocable beneficiary and/or assignee (if applicable) consent(s) to the conversion of the coverage specified in this application.

_____ Date: | | | | | | | | | Signed at: _____
Signature of Irrevocable Beneficiary (if any) Day Month Year City/Town Province

_____ Date: | | | | | | | | | Signed at: _____
Signature of Assignee (if any) Day Month Year City/Town Province

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15-45 02/19

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. 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.