Manulife

ALBERTA MEDICAL ASSOCIATION

Application for Insurance

For the members of the Alberta Medical Association and/or their spouse

1. Member information

In this application, *we*, *us* and *our* refer to the Manufacturers Life Insurance Company. *You* and *your* refer to the person to be insured.

You will be billed personally unless otherwise requested below

*A Non-smoker is someone who has not used any form of tobacco or tobacco cessation products, including the use of e-cigarettes and vaporizers within the past 12 months.

Member AMA#

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth: (dd/mm/yy):

Province of birth: Country of birth:

Address (street number or name): Apartment or Suite:

City: Province: Postal Code:

Email Address (optional):

Telephone (Residence): Telephone (Cell):

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

1.2 Business Information

Business address (street number or name): Apartment or suite:

City: Province: Postal Code:

Telephone (Business): Fax:

1.3 Contact preference

Send correspondence to: ☐ Residence address ☐ Business address

May we correspond with you via email so that we may contact you for the administration of this application? ☐ Yes ☐ No

Preferred phone number and time to contact member: ☐ Residence ☐ Business ☐ Cell

☐ Monday to Friday	☐ Saturday	☐ Sunday
☐ Morning (6:00-12:00)	☐ Morning (6:00-12:00)	☐ Morning (6:00-12:00)
☐ Afternoon (12:00-5:00)	☐ Afternoon (12:00-5:00)	☐ Afternoon (12:00-5:00)
☐ Evening (5:00-10:00)		

1.4 Spouse information (if applying for insurance)

*A Non-smoker is someone who has not used any form of tobacco or tobacco cessation products, including the use of e-cigarettes and vaporizers within the past 12 months.

Last Name: First Name: Middle Initial:

Dr. ☐ Mr ☐ Ms ☐ Mrs. ☐ Miss ☐

Former Maiden Name (if applicable): Date of Birth (dd/mm/yy):

Province of birth: Country of birth:

☐ Same address as member, or

Address: Apartment or Suite:

City: Province: Postal Code:

1.4 Spouse information (if applying for insurance continued)

Email Address:

☐ Non-smoker* ☐ Smoker ☐ Male ☐ Female

Telephone (Residence): Telephone (Business):

Fax: Telephone (Cell):

Occupation Amount of annual income ($)

1.5 Spouse Contact preference

Send correspondence to: ☐ Residence address ☐ Business address

May we correspond with you via email so that we may contact you for the administration of this application? ☐ Yes ☐ No

Preferred phone number and time to contact member: ☐ Residence ☐ Business ☐ Cell

☐ Monday to Friday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)
- ☐ Evening (5:00-10:00)

☐ Saturday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)

☐ Sunday
- ☐ Morning (6:00-12:00)
- ☐ Afternoon (12:00-5:00)

2.1 Member Life insurance

Minimum $50,000, Maximum $5,000,000, in units of $50,000

If no beneficiary is designated, benefits will be payable to the Estate.

If you wish to name a secondary beneficiary, multiple beneficiaries, or your beneficiary is a minor, contact adium@albertadoctors.org for a beneficiary form.

Amount of new insurance applied for at this time ($)

Waiver of Premium rider ☐ Yes Future Insurance Option rider ☐ Yes

Beneficiary last name: Beneficiary first name):

Relationship to the proposed insured:

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for.

2.2 Spouse Life insurance

Minimum $50,000 , Maximum $5,000,000 in units of $50,000

If no beneficiary is designated, benefits will be payable to the Estate.

If you wish to name a secondary beneficiary, multiple beneficiaries, or your beneficiary is a minor, contact adium@albertadoctors.org for a beneficiary form.

Amount of new insurance applied for at this time ($)

Waiver of Premium rider ☐ Yes Future Insurance Option rider ☐ Yes

Beneficiary last name: Beneficiary first name):

Relationship to the proposed insured:

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for.

2.3 Member Disability insurance

Minimum $500, Maximum $25,000, in units of $100

Amount of new insurance applied for at this time ($)

30 days 60 days 90 days 120 days

Indicate any optional riders applied for:

- ☐ Cost of Living Adjustment
- ☐ Guaranteed Insurability Benefit
- ☐ Own Occupation
- ☐ Lifetime Accident Total Disability
- ☐ Retirement Protection
  - ☐ $500 monthly contribution benefit
  - ☐ $ 1,000 monthly contribution benefit

2.4 Member Professional Overhead Expense (POE) insurance

Minimum $500, Maximum $30,000 (Maximum $8,000 if applying for 14-day elimination period), in units of $100

Amount of new insurance at 14-day elimination period applied for at this time ($)

14 days (up to $8,000) _____ 30 days (up to $30,000) _____

Indicate any optional riders applied for: ☐ Guaranteed Insurability Benefit

2.5 Critical Illness insurance

Member Critical Illness insurance

Minimum $50,000, Maximum $1,000,000, in units of $10,000

Amount of new insurance applied for at this time ($)

_____ Waiver of Premium rider: ☐ Yes

Spouse Critical Illness insurance

Minimum $50,000, Maximum $1,000,000, in units of $10,000

Amount of new insurance applied for at this time ($)

_____ Waiver of Premium rider: ☐ Yes

Child information if applying for Dependent Child Critical Illness insurance

Amount of new insurance applied for at this time

☐ $5,000 ☐ $10,000 ☐ $ 15,000 ☐ $20,000

Child's last name	Child's first name	Date of birth (dd/mm/yyyy)	Gender
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

3. Insurance Information

Note: Do not cancel any existing coverage until the coverage you have applied for has been approved.

a) Do you have any pending or existing disability, professional overhead expense, life or critical illness insurance other than AMA or PARA group insurance plans or creditor insurance for mortgage or loan amounts?

☐ Yes ☐ No If yes, provide details below

Name of applicant	Amount of benefit ($)	Type of coverage	Insuring Company

Date of issue (mm/ yyyy)	Benefit period	Taxable
		☐ Yes ☐ No

Name of applicant	Amount of benefit ($)	Type of coverage	Insuring Company

Date of issue (mm/ yyyy)	Benefit period	Taxable
		☐ Yes ☐ No

b) Will any insurance be discontinued if this coverage you have applied for is issued?

☐ Yes ☐ No If yes, provide details below

Insuring Company _____

Type of coverage: _____ Amount: _____

4. Occupational Information

a) Occupation/Specialty:

If you are a practicing physician complete questions b-f:

b) Are you self-employed? ☐ Yes ☐ No ☐ Both

If yes, business structure: ☐ Sole proprietor ☐ Partnership ☐ Corporation % ownership

If no, name of employer:

c) Date initial medical practice commenced in Canada (if within the last 2 years) (dd/mm/yyyy):

d) Number of hours worked per week in the practice of medicine (if less than 25, explain why):

e) Number of weeks worked per year in the practice of medicine (if less than 46 weeks per year, explain why):

f) Have you changed your job duties, location and/or hours of work in the past 2 years, or do you contemplate such changes within the next 12 months?

☐ Yes ☐ No If yes please describe:

5. Financial Information

Complete this section if you are a member and applying for Disability Insurance

Have you ever declared or are you contemplating bankruptcy?: ☐ Yes ☐ No

If yes, date of discharge (dd/mm/yyyy)

	Current year-to-date		**Actual last year**
	From (mm/yyyy)	To (mm/yyyy)	(yyyy)
Gross annual income before business expenses (A)	$		$
Less annual total of all your business expenses (B)	$		$
Net annual income before taxes (A) - (B)	$		$
Is any portion of your income from a salaried position? ☐ Yes ☐ No	If yes, provide salary $		
Do you have any unearned income not dependent on your ability to work in excess of $30,000 or 15% of your insurable net annual income before taxes? ☐ Yes ☐ No	If yes, amount of unearned income $		Source of unearned income

6. Income documentation for Disability insurance

If you are applying for Disability insurance, financial documents are required to confirm your income (unless you are in residency or have commenced your initial medical practice in Canada in the last 2 years).

The following income documentation will be required depending on your business structure.

Employed (salaried)

- Most current T4 or,
- Income tax return - t1 (pages 1-4)

Sole Proprietor or Partnership

- Income tax return - T1 (pages 1-4) and,
- Statement of Business or Professional Activities (T2125)

Incorporated

- Most current T4 or,
- Personal income tax return - T1 (pages 1-4) and,
- Business Financial Statements of the Corporation

7. Expense documentation for Professional Overhead Expense insurance

If you are applying for Professional Overhead Expense insurance that exceeds a total of $10,000 per month, financial documents are required to confirm your expenses.

The following income documentation will be required depending on your business structure.

Sole Proprietor or Partnership

- Statement of Business or Professional Activities (T2125)

Incorporated

- Business Financial Statements of the Corporation

8. Accountant Information

☐ I am enclosing the required documentation, or
☐ Contact my accountant to obtain the required income documentation

Accountant Last Name: First Name:

Address (street number or name): Apartment or Suite:

City: Province: Postal Code:

Email Address:

Telephone (Residence): Telephone (Cell): Fax:

9. Declaration and Authorization

I /We (the Member/Spouse) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I declare that the statements contained in this application, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any coverage issued hereunder. I understand that any material misrepresentation including misstatement of smoker status shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. I understand that there are exclusions and limitations on the coverage applied for.

Relative to the insurance applied for, I, the undersigned person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company,the MIB 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 for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose. I authorize Manulife to hold a personal file about myself and my insurance coverage. I authorize Manulife, the plan administrator, and their authorized staff, agents, representatives, advisors and service providers to use and exchange information needed for underwriting, financial management, administration and adjudication of claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers. A photocopy or faxed copy 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 in connection with this application, Manulife may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law.

I/We hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

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

If my/our application is approved, I/we will receive a certificate of insurance specifying the coverage provided and the main policy provisions.

9. Declaration and Authorization (continued)

Signed at (city or town): Signed at (province):

Name of member: Name of spouse:

Signature of member: Date (dd/mm/yyyy):

Signature of spouse: Date (dd/mm/yyyy):

Note: Your completed application must be submitted within one month of the date you sign.

Return your completed application to:
ADIUM Insurance Services Inc CMA Alberta House
12230 106 Avenue NW Edmonton AB T5N 3Z1
Fax: 780-488-7558 or 1-877-302-3486
Email:adium@albertadoctors.org

Transmitting your personal information electronically is not a secure method of electronic communication and has several risks associated with it. We encourage you to use the AMA Member Dashboard (http:www.albertadoctors.org/dashboard) for the exchange of personal information.

For general information:
Call Toll-free: 1-888-492-3486
Website: www.albertadoctors.org

10. Premium payments

Monthly or Annual pre-authorized debit (PAD)
Indicate payment frequency:

- ☐ Monthly (interest free)
- ☐ Annual (full payment for balance of calendar year and annually the first week of January thereafter)
- ☐ Please add payments to my existing pre-authorized debit plan

Complete this section if you're making payments by pre-authorized debit
Attach a void cheque from the account you wish to be debited, OR complete this section

Account holder first name: Account holder last name:

Address of your Canadian bank or financial institution (street number and name)

Name of Canadian bank or financial institution: Transit number:

Institution number: Account number:

Joint Accounts: Is this a joint account requiring more than one signature? ☐ Yes ☐ No

If more than one signature is required on withdrawals issued from the account, both account holders must sign this authorization.

Signature of account holder: Date (dd/mm/yyyy):

Signature of account holder: Date (dd/mm/yyyy):

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing priviledges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withrdawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

11. Premium Authorization

I/We authorize the Alberta Medical Association (AMA) to collect the monthly premium (including applicable provincial tax) for this insurance through Pre-Authorized Debit (PAD). I/We acknowledge that my/our financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. I/We acknowledge that the amount of the monthly premium (including applicable provincial tax) collected through this agreement may vary. I/We agree to waive the requirement that the AMA notify me/us of any payments after the first payment whether the amount of the monthly premium is changed or not. I/We understand that the monthly premium is due the first of each month. This agreement will be cancelled automatically if the AMA is unable to make a withdrawal from my/our account.

This authorization is to remain in effect until the AMA has received written notification from myself/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. I/We may obtain a sample PAD cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca.

The AMA may not assign this authorization to another company or person to permit them to debit my/our account for these payments (for example where there has been a change in control of the company) without providing at least 10 days' prior written notice to me/us.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca.

ADIUM Insurance Services Inc.
CMA Alberta House
12230 106 Avenue NW Edmonton, AB T5N 3Z1 adium@albertadoctors.org

12. Notice of Exchange of Information

Information about MIB, Inc.
We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, Inc. based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, Inc. is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, Inc. will share any information it has on file.
You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at:
MIB, Inc.
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@ mib.com

13. Notice on Privacy and Confidentiality

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 Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. 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, Waterloo, ON N2J 4C6.

The Alberta Medical Association (AMA), in its role as plan administrator adheres to all applicable provincial and federal privacy legislations regarding the collection, use, disclosure, retention and safeguarding of personal information. Compliance with these principles is reviewed regularly and revised as needed. For more information on the AMA's privacy commitment, please refer to our website, www.albertadoctors.org/ privacy/commitment

Underwritten by The Manufacturers Life Insurance Company (Manulife).