

Application to exercise the guaranteed insurability benefit rider

The Alberta Medical Association Disability Insurance Plan

1. General 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.

AMA# _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: (dd-mm-yyyy): _____ Address (street number or name): _____

Apartment or Suite: _____ City: _____ Province: _____

Postal Code: _____ Email Address (optional): _____

Preferred telephone number: _____ Male Female

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

2. Coverage applied for

In \$100 units to a maximum of \$2,500.
The elimination period will be the same elimination period that the rider is attached to.

Amount of additional monthly benefits applied for at this time: \$ _____

3. Occupational information

Note: Any amount approved during a period of disability will apply only to any new disability.

a. Occupation/Specialty _____

b. Date commenced medical practice (if within last 2 years) (dd-mm-yyyy) _____

c. Number of hours worked per week If less than 25 hours, explain: _____

d. Number of weeks worked per year If less than 46 weeks, explain: _____

e. 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, explain _____

f. Are you now disabled and/or on claim and/or satisfying an elimination period? Yes No
If yes, indicate the date you became disabled (dd-mm-yyyy): _____

4. Insurance Information

Other than your coverage through the AMA, do you have in-force or have you concurrently applied for any disability income coverage (including coverage through your employer)? Yes No

If yes, provide the details below:

Amount of Benefit	Insurance Company	Elimination period	Indicate if individual or group/association	Taxable Benefit
\$ _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Will any Disability insurance be discontinued if this application is approved? Yes No

If yes, provide the details below:

Insuring Company: _____ Amount: \$ _____

5. Financial Information

a. Have you ever declared or are you contemplating bankruptcy? Yes No

If yes, date of discharge (dd-mm-yyyy): _____

b. Indicate your business structure

Employee Sole owner Partnership Professional corporation - if incorporated, % of ownership: _____

c. 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 Earned Income? Yes No

If yes, amount of unearned income: \$ _____

Source of unearned income: _____

d. Do you have any income that will continue under a partnership arrangement or employment contract, should you become disabled? Yes No

If yes, provide amount and details: _____

e.

Last year

Previous Year

Net annual earned income (gross income less business expenses) \$ _____

\$ _____

If you are incorporated, state your salary shown on your T4 (tax slip) _____

\$ _____

If you are an employee (other than through your professional corporation) state your salary shown on your T4 (tax slip) _____

Indicate your employer name: _____

\$ _____

f. If your spouse or dependents receive income from your business, state how much (maximum of \$30,000) _____

\$ _____

Unearned income includes investment income not dependent on ability to work, but does not include RRSPs.

6. Income documentation for Disability insurance

If you are applying for Disability insurance, financial documents are required to confirm your income

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. Accountant Information

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

Last Name: _____

First Name: _____

Company Name: _____

Address (street number or name): _____

Apartment or Suite: _____

City: _____

Province: _____

Postal Code: _____

Email Address (optional): _____

Telephone (Residence): _____

Telephone (Cell): _____

Fax: _____

8. Declaration and authorization

I (the Member) 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 shall render any insurance issued pursuant to this application voidable at the instance of the insurer. 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 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 the insurance coverage, 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 acknowledge my receipt of and agreement with the Personal Information Statement.

Signed at (city or town):

Signed at (province):

Date (dd/mm/yyyy):

Signature of member:

Return your completed application to:
ADIUM Insurance Services Inc
Alberta Medical Association
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 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.

9. Personal Information Statement

In this Statement, “you” and “your” refer to the policyowner or holder of rights under the contract, the insured and the parent or guardian of any child named as insured who is under the legal age for 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, your date of birth, or driver's license
- Medical information that any organization or person has about you
- A personal investigation, financial information, credit bureau report and/or a consumer report from other organizations, 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
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- 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.

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 1-888-MANULIFE (626-8543), or 1-888-MANUVIE (626-8843) in Quebec, 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, 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 500 King Street N. 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.

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