Manulife

ALBERTA MEDICAL ASSOCIATION

Application to exercise the guaranteed insurability benefit rider for residents

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.

Complete this application if you are applying within 60 days of successful completion of a medical residency program.

AMA #

Last Name: | First Name: | Middle Initial:

Date of Birth: (dd/mm/yy): | 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

Indicate the dates that you:

a) completed residency — Date (dd-mm-yyyy)

b) commenced/commencing practice in your specialty — Date (dd-mm-yyyy)

c) commenced/commencing fellowship training — Date (dd-mm-yyyy)

2. Coverage applied for

In $100 units (see letter for available amounts)

Amount of additional monthly benefits **applied for at this time.**

☐ $ _____ or ☐ The maximum amount available for first year physicians

3. Occupational Information

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

Occupation/Specialty:

1) Number of hours worked per week:

If less than 25 hours, explain:

2) Number of weeks worked per year:

If less than 46 weeks, explain:

4. Insurance Information

Other than AMA insurance, 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 details below :

Amount of monthly benefit	Type of coverage	Insuring company or plan	Indicate if individual or group/ association	Date of issue (mm-yyyy)	Elimination period (ie. 90 days)	Benefit period (ie. 5 yrs to age 65)	Taxable
$							☐ Yes ☐ No
$							☐ Yes ☐ No

Will any Disability insurance be discontinued if this application is approved?

☐ Yes ☐ No If yes, provide 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. 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:

c. Are you now disabled and/or on claim and/or satisfying an elimination period? ☐ Yes ☐ No

If yes, provide details:

6. 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 Notice on Privacy and Confidentiality.

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.

7. 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).