Manulife

ALBERTA MEDICAL ASSOCIATION

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/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

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 hours, 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
$				☐ Yes ☐ No
$				☐ Yes ☐ 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 % 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.

Proof of income may be required to ensure that your disability benefits are appropriate to your insurable 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. 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 (Business): 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 Notice on Privacy and Confidentiality.

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

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

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

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. 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).