Application for Insurance

Sun Life Financial

ALBERTA MEDICAL ASSOCIATION

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

In this application you and your refer to the person applying for insurance. We and the Company refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Clear

Member/spouse information

Member information

Last name	First name	Middle initial	☐ Dr. ☐ Mr. ☐ Ms ☐ Mrs. ☐ Miss

☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Former/maiden name (if applicable)

Province of birth	Country of birth	☐ Non-smoker ☐ Smoker	Non-smoker means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.

Residence address (street number and name)	Apartment or suite

City	Province	Postal code

Send correspondence to: ☐ Residence address ☐ Business address	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 (9:00–12:00) ☐ Afternoon (12:00–2:00)

Telephone (residence)	Telephone (business)	Fax	Telephone (cell)

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

Member AMA#	You will be billed personally unless otherwise requested below

Business address (street number and name)	Apartment or suite

City	Province	Postal code

Spouse information (if applying for spouse coverage)

Last name	First name	Middle initial	☐ Dr. ☐ Mr. ☐ Ms ☐ Mrs. ☐ Miss

☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Former/maiden name (if applicable)

Province of birth	Country of birth	☐ Non-smoker ☐ Smoker	Non-smoker means that you have not used any tobacco or tobacco cessation products within the last 12 consecutive months.

☐ Same address as member

Residence address (street number and name)	Apartment or suite

City	Province	Postal code

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

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Member/spouse information (continued)

Preferred phone number and time to contact spouse:
☐ Residence ☐ Business ☐ Cell ☐ Monday to Friday ☐ Saturday ☐ Sunday
☐ Morning (6:00–12:00) ☐ Morning (6:00–12:00) ☐ Morning (9:00–12:00)
☐ Afternoon (12:00–5:00) ☐ Afternoon (12:00–5:00) ☐ Afternoon (12:00–2:00)
☐ Evening (5:00–10:00)

Telephone (residence)	Telephone (business)	Fax	Telephone (cell)

Occupation	Amount of annual income
	$

Coverage applied for

Member Life insurance

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

Amount of new insurance applied for at this time	Waiver of premium rider	Future Insurance Option rider
$	☐ Yes	☐ Yes

Beneficiary last name	Beneficiary first name	Relationship to the proposed insured

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

Spouse Life insurance

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

Amount of new insurance applied for at this time	Waiver of premium rider	Future Insurance Option rider
$	☐ Yes	☐ Yes

Beneficiary last name	Beneficiary first name	Relationship to the proposed insured

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

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

Please indicate the optional riders applied for at this time:

☐ Cost of Living Adjustment
☐ Guaranteed Insurability Benefit
☐ Own Occupation
☐ Retirement Protection:
☐ $500 monthly contribution benefit
☐ $1,000 monthly contribution benefit

Member Professional Overhead Expense (POE) insurance

Minimum $500, Maximum $20,000 (Maximum $7,000 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	Amount of new insurance at 30-day elimination period applied for at this time
$ **(up to $7,000)**	$ **(up to $20,000)**

Please indicate the optional rider applied for at this time:

☐ Guaranteed Insurability Benefit

Member Critical Illness insurance

Minimum $50,000, Maximum $250,000, in units of $10,000

Amount of new insurance applied for at this time	Waiver of premium rider	Beneficiary
$	☐ Yes	**ESTATE**

Spouse Critical Illness insurance

Minimum $50,000, Maximum $250,000, in units of $10,000

Amount of new insurance applied for at this time	Waiver of premium rider	Beneficiary
$	☐ Yes	**ESTATE**

Are you applying for Dependent Child Critical Illness (CI) insurance? ☐ Yes

Coverage applied for (continued)

Child information

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

Insurance information

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

a) Do you currently have insurance or have you concurrently applied for any sickness or accident (including Disability insurance through your employer), Professional Overhead Expense, Critical Illness or Life insurance coverage provided by individual or group policies, or employment contracts/partnership agreements (other than AMA, PARA insurance or creditor insurance for mortgage or loan amounts)?

☐ Yes ☐ No If *yes*, please provide details below.

Name of applicant	Amount of benefit	Type of coverage (Disability, POE, Life, CI)	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*, please provide details below.

Insuring company	
Type of coverage	Amount $

Occupational information

a) Occupation

If you are a practicing physician complete questions b to 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 two years) (dd-mm-yyyy)

d) Numbers of hours worked per week in the practice of medicine

e) Numbers of weeks worked per year in the practice of medicine

f) Have you changed your job duties, location and/or hours of work in the past two years, or do you contemplate such changes within the next year? ☐ Yes ☐ No

If *yes*, please describe:

Financial information (Please 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*, please provide salary $	
Do you have any unearned income not dependent on your ability to work in excess of $10,000 per annum (e.g. net investment income from securities, banks, real estate, etc.) ☐ Yes ☐ No	If *yes*, amount of unearned income $	Source of unearned income

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 two years).

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

Employee (Salaried)	Sole Proprietor or Partnership	Incorporated
• Most current T4 or, • Income Tax Return -T1 (pages 1 to 4)	• Income Tax Return -T1 (pages 1 to 4) and, • Statement of Business or Professional Activities (T2125)	• Most current T4 or, • Personal Income Tax Return -T1 (pages 1 to 4) and, • Business Financial Statements of the Corporation

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	Incorporated
• Statement of Business or Professional Activities (T2125)	• Business Financial Statements of the Corporation

Accountant's information

☐ I am enclosing the required documentation, ***or***

☐ Please contact my accountant to obtain the required income documentation.

Accountant's last name	First name		
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Telephone number	Fax number	Email address	

Declaration and authorization (Please read and sign this section)

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application will cause the insurance to be void. MEMBER ONLY: I also certify that as member of the Alberta Medical Association or the Northwest Territories Medical Association, I understand and agree that this application is void unless I am in active practice in Canada on the date of this application.

I hereby certify that I have read and understood the Medical Information Bureau (MIB) pre-notification notice section below, and having read the contents, I have, by my signature below, authorized the MIB to give to Sun Life Assurance Company of Canada or its reinsurer(s), any information it may have.

I authorize Sun Life Assurance Company of Canada, the plan administrator (ADIUM Insurance Services Inc.), and their agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original.

Member's last name (please print)	Member's first name (please print)	Spouse's last name (please print)	Spouse's first name (please print)

Signature of member	Signature of spouse
X	X

Location signed (city)	Location signed (province)	Date signed (dd-mm-yyyy)

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

Please 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*

We retain the right to request a medical examination, urinalysis or tests such as a blood profile (including a blood test for HIV) which will be made at no expense to you. You may be contacted by a representative of the Company for your medical history.

Premium payments

Monthly or Annual pre-authorized payment (PAP)

Please 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 payment plan

Please complete this section if you'd like to have the AMA collect your premium payment(s) directly from your bank account.

Please include a blank cheque, marked VOID, from the account you wish to be debited, OR complete this section.

First name of account holder	Middle initial	Last name

Name and address of your financial institution (street number and name)

Transit #	Institution #	Account #

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the terms and conditions on page 5.

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder	Date (dd-mm-yyyy)
X	

Signature of account holder	Date (dd-mm-yyyy)
X	

Premium payments (continued)

Terms and conditions

You authorize the Alberta Medical Association (AMA) to collect, depending on your selection, the monthly or annual premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that the AMA notify you of any payments after the first payment whether the amount of the monthly or annual premium is changed or not**. You understand that if you selected the monthly payment option, the monthly premium is due the first of each month; if you selected the annual payment option, the annual premium payment will be due the first of January each year. This agreement will be cancelled automatically if the AMA is unable to make a withdrawal from your account.

This authorization is to remain in effect until the AMA has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your 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 your 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 you.

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

Medical Information Bureau notice

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you to its reinsurers. Sun Life Assurance Company of Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sun Life Assurance Company of Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to the MIB at: Medical Information Bureau
330 University Avenue
Toronto, Ontario M5G 1R7
or call: 416-597-0590

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.