Manulife

Doctors Manitoba

Future Insurance Option Application – FIO1

DOCTORS MANITOBA

Please PRINT clearly in ink.

1 MEMBER INFORMATION

FIO under Certificate Number:

Name (last, first, middle initial)		Date of birth (dd/mm/yyyy)
Mailing address (street number and name, apartment or suite)		
City/Town	Province/Territory	Postal code
E-mail address (residence)		Telephone (residence) ( )
E-mail address (business)		Telephone (business) ( )

2 ADDITIONAL INSURANCE COVERAGE APPLIED FOR

Disability Income Insurance Increase Option Amount Selected:	☐ $500	☐ $400	☐ $300	☐ $200	☐ $100
Waiting Period*	☐ 14 Days**	☐ 30 Days	☐ 60 Days	☐ 90 Days	☐ 180 Days

* The waiting period selected may not be less than the waiting period currently in force.

** The current in-force coverage plus the additional coverage selected above may not exceed $5,500 at 14 Day Waiting Period.

3 INSURANCE INFORMATION

3.1 Describe all coverage in force or applied for in the box below.

	Name of Insurance Company	Amount of Disability	Waiting and Benefit Period	Taxable or Non Taxable	Date Issued (Month/Year)	Do you intend to replace this coverage?
a)						☐ Yes ☐ No
b)						☐ Yes ☐ No
c)						☐ Yes ☐ No
d)						☐ Yes ☐ No

3.2 **Note:** If you intend to replace coverage (other than coverage you may have through an employer group benefits plan), do not cancel your existing coverage until the new coverage has been approved. A replacement form or declaration may be required. Manulife may not be able to issue an insurance certificate if replacement is indicated.

4 FINANCIAL AND OCCUPATIONAL INFORMATION

Please check as appropriate and attach financial document where indicated.

The guide on the next page of this application will determine the level of coverage you are eligible to apply for.

4.1

☐ *New* General Practitioner – in first 2 years after graduating from a Residency Program – Disability amount from all sources is $7,000 or less – proof of income not required.

☐ *New* Specialist – in first 2 years after graduating from a Residency Program – Disability amount from all sources is $10,000 or less – proof of income not required.

☐ Fee for service physician with over 2 years in practice, and coverage applied for and in force exceeds $3,500 – Attach Pages 1, 2 and 3 of last 2 years' tax returns plus Statement of Professional or Business Activity. If incorporated, also attach the latest Corporate Financial Statement.

☐ Employed physician with over 2 years in practice, and coverage applied for and in force exceeds $3,500 – Attach copy of salary/employment letter or Pages 1, 2 and 3 of last tax return. (Ensure you provide details of any group coverage through your employer in Section 3, Question 3.1.).

☐ Manager of a medical clinic – Attach copy of salary/employment letter or Pages 1, 2 and 3 of last tax return.

☐ OTHER – Please fully describe under separate cover and provide financial documentation to support.

4.2 Do you have any income which will become payable or continue should you become disabled? ☐ Yes ☐ No
If **yes**, provide details:_____

4.3 Are you disabled and on claim or satisfying your waiting period? (Any amount exercised during a period of disability will apply only to any new disability.) ☐ Yes ☐ No

(see next page)

4 FINANCIAL AND OCCUPATIONAL INFORMATION (continued)

Your calculation of the additional premium is as follows:

Number of Units Selected _____ x Annual Basic Premium per Unit $_____ = $ 0 **(1)**
(maximum is 5 Units) (for the selected Waiting Period at your age)

Plus the premium for the Own Occupation Option (if eligible)
If this Option rider is in force on basic coverage, it must be included in the coverage applied for on this application.

.20 x Basic Premium from **(1)** _____ = $ 0 **(2)**

Plus the premium for the Cost of Living Adjustment Option (COLA) (if eligible)
If this Option rider is in force on basic coverage, it must be included in the coverage applied for on this application.

Number of Units Selected _____ x Annual COLA Premium per Unit $_____ = $ 0 **(3)**
(maximum is 5 Units) (at your age)

Total additional annual premium **(1)** + **(2)** + **(3)** = $ 0

5 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, Del Stn 500-4-A, Waterloo, ON, N2J 4C6.

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. I understand that this application, together with any other documents provided in connection with this application, shall be the basis on which the increase is granted. I understand that any material misrepresentation shall render the additional insurance voidable at the instance of the insurer. I consent to the additional insurance being placed on my life.

I acknowledge receipt of, and confirm my agreement with, the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.

I authorize Doctor's Manitoba, Manulife and their subsidiaries, affiliates and agents to use the information in this application and their existing files to offer me their products or services. I understand that my consent to the use of such information to offer me products or services is optional and that if I wish to discontinue such use I may write to: Privacy Officer, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, ON, N2J 4C6.

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 subject to Manulife's receipt of the properly completed application form and the first premium payment, the Option Amount will take effect on the option date following approval by Manulife's underwriters.

If approved, I understand that the new coverage will be issued subject to the terms of the Option rider under which this option has been exercised and will be subject to the same exclusions and limitations specifically excluded from coverage under the original certificate. If not approved, a full refund of any premiums paid will be made.

A photocopy or faxed copy of this authorization shall be as valid as the original.

Signed in the City/Town of_____, and Province of_____Date_____(dd/mm/yyyy)

Signature of Member_____Signature of Witness_____

Underwritten by
The Manufacturers Life Insurance Company.