

# Application for PARIM Group Insurance (MANDATORY)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: Male  Female  Smoking Status: Smoker  Non-Smoker

You are considered a smoker if you have smoked or used tobacco of any kind including cessation products, e -cigarettes, or vaping within the last 12 months

Start Date: \_\_\_\_\_ PGY Level: \_\_\_\_\_ Grad Date: \_\_\_\_\_

## Term Life Insurance - Policy 335300 Provided by Great West Life

Coverage: \$130,000

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Beneficiary will receive 100% of benefits unless otherwise noted

### Select One Payment Mode

Automatic Deduction - Lump Sum (RECOMMENDED)

Lump Sum Payment Enclosed (submit your cheque)

Coverage renews every January 1st

## Long Term Disability - Policy 521 Provided by Manufacturer's Life Insurance Company

Select Monthly Benefit: \$3,500  \$4,000

Your coverage includes the Cost of Living Adjustment rider (COLA) and the Future Insurance Option (FIO)

### Select One Payment Mode

Automatic Deduction - Lump Sum (RECOMMENDED)

Automatic Deduction - Monthly Payment (RECOMMENDED)

Lump Sum Payment Enclosed (submit your cheque)

Coverage renews every June 1st

## Accidental Death & Dismemberment - Policy 100004790 Provided by Industrial Insurance and Financial Services Inc.

Coverage: \$50,000

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Beneficiary will receive 100% of benefits unless otherwise noted

Premiums will be combined with your Disability Premiums. Coverage renews every June 1st.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you have selected an automatic deduction for any of your payment options, please be sure to complete the Pre-authorized Deduction Application form!**

# Pre-Authorized Deduction Authorization Form

Please check the option(s) that correspond with your selections on the Insurance Application form. Be sure to complete your name and email, and to sign and date the form

Name: \_\_\_\_\_ Email: \_\_\_\_\_

## DEDUCTION OPTIONS

### Disability and Accident Insurance

Annual Deduction OR  Monthly Deduction

- \* Add \$2.00 Service Charge
- \* Initial Deduction to be on or about July 1, 2018
- \* Renewal Deduction to be on or about June 1 annually

- \*Takes place on the 10th of each month
- \* Add \$2.00 Service charge per deduction
- \* Initial Deduction to be on or about June 10, 2018

### Term Life Insurance

Annual Deduction

- \* Add \$2.00 Service Charge
- \* Initial Deduction to be on or about July 1, 2018
- \* Renewal Deduction to be on or about January 2 annually

Please attach a copy of a VOID cheque or an authorization form obtained from your financial institution, or complete the information below. **Note that automatic deductions cannot be taken from a Line of Credit Account**

Transit # (5 digit)  Bank # (3 digit)  Account # (up to 12 digits)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Please complete the Pre-Authorized Debit (PAD) agreement below.

I/We authorize and instruct Doctors Manitoba and my/our designated financial institution (or any other financial institution I/we may authorize at any time) to deduct regular recurring payments for all charges arising from my/our Doctors Manitoba insurance(s) as indicated above. Monthly payments will be debited from my/our specified account on the 10th or 20th day of each month. Annual payments will be debited to my/our specified account on the first business day of January or June/July. I/We understand that the amount of the deduction may change at a future date and, if so, that pre-authorized debits will continue and reflect such changes. Doctors Manitoba will advise me/us in writing of the revised amount at least ten (10) days before the debit date.

I/We acknowledge and agree that Doctors Manitoba may charge me/us an administration fee of up to \$10 per occurrence for any dishonoured pre-authorized debit (including, but not limited to, non-sufficient funds, stop payments and closed accounts).

Doctors Manitoba may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (10) days prior written notice to me/us.

I/We understand that this authority will remain in effect until I deliver to Doctors Manitoba a written notification from me/us changing or terminating it. I/We understand that I/we must provide at least ten (10) business days notice to Doctors Manitoba before the next debit is scheduled. I/We may obtain a sample cancellation form, or more information on my/our right to cancel, at my/our financial institution. I/We understand that I/we have certain recourse rights if any debit does not comply with this authorization. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this authorization. I/We understand that I/we may obtain a form for a Reimbursement Claim, or more information on recourse rights, from my/our financial institution or at [www.cdnpay.ca](http://www.cdnpay.ca).