Manulife **The Manufacturers Life Insurance Company**

CANADIAN DENTISTS' INSURANCE PROGRAM

A member benefit of the CDA and participating provincial and territorial dental associations.

CDSPI

17-

APPLICATION

DisabilityGuard™ Insurance/ Office Overhead Expense Insurance

For assistance in filling out this application, call: **CDSPI Advisory Services Inc.**
1-800-561-9401 (toll-free) or (416) 296-9401, E-mail: insurance@cdspi.com

Please complete all pertinent questions to avoid processing delays, and return to: **CDSPI**,
155 Lesmill Road, Toronto, Ontario M3B 2T8 Fax: 1-866-337-3389 (toll-free) or (416) 296-8920

Accessible formats and communication supports are available upon request. Visit **cdspi.com/accessibility** for more information.

Section 1 Applicant Information

1. Name (*please print*):
Check one: ☐ Dr. ☐ Corporation†

Last First Middle or Middle Initial
(*or name of partnership or corporation*)

2. Individuals only: ☐ Male ☐ Female

3. Mailing Address: Check one: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

4.
Business Telephone Home Telephone

Mobile Telephone Fax

5. E-mail address (*please include to expedite the application process*)

6. A. Account Number, if known:

B. Billing Preference (check one):
- ☐ Same as current
- ☐ Annual*
- ☐ Quarterly*
- ☐ Monthly*
- ☐ Pre-authorized chequing*
- ☐ Automatic VISA/MasterCard*

* To pay monthly, quarterly or annually under this option, you must complete and send in a pre-authorized payment plan form. To obtain this form, visit **www.cdspi.com/pac-insurance**. **Note:** A 2.23% processing charge applies to monthly and quarterly payments.

7. Language Preference: ☐ English ☐ French

† **Note:** A Corporation is not normally the applicant for Long Term Disability coverage due to tax implications. Contact CDSPI Advisory Services Inc. for further details.

Section 2 Person To Be Insured

Note: Please complete even if the person to be insured is the same as the applicant.

1. Name of Dentist (*please print*):
☐ Dr.
Last First Middle or Middle Initial

2. ☐ Male ☐ Female

3. ☐ Smoker ☐ Non-Smoker‡

4. Date of Birth: D D M M Y Y Y Y

5. Country of Birth:

6. CONFIRM STATUS:
☐ Member of CDA/Provincial/Territorial Dental Association*
* Excluding the ACDQ in Quebec.
(Dentists in Quebec must be members of the CDA)

Dental Specialty (if applicable):

Date of Graduation: D D M M Y Y Y Y

Name of University or Dental Faculty:

7. Date you commenced practice as a Dentist: D D M M Y Y Y Y

8. a) Is Dentistry considered your full time occupation? ☐ Yes ☐ No
b) Minimum hours:
c) Average hours per week:

9. a) Do you have any other occupation? ☐ Yes ☐ No
b) If yes, please list all other occupations, your job duties and percentage of time performing these duties.

10. a) Have you ever used any tobacco or tobacco cessation products?‡ ☐ Yes ☐ No
If yes, provide details:
b) If you smoke cigars, state how many smoked per month:

‡ **Note:** You are considered a non-smoker if you have not used any form of tobacco or tobacco cessation products in the 12 months prior to signing this application. Note, however, that you must be approved by the insurer for non-smoker rates and that such approval is dependent on your smoking status and overall health history.

Plan underwritten by The Manufacturers Life Insurance Company

COVERAGE APPLIED FOR

Section 3 DisabilityGuard™ Insurance

1. Monthly Income Benefit applied for at this time (do not include existing coverage) in increments of $100:

30 Day Elimination Period $ _____ ☐ Step Premium ☐ Level Premium

60 Day Elimination Period $ _____ ☐ Step Premium ☐ Level Premium

90 Day Elimination Period $ _____ ☐ Step Premium ☐ Level Premium

120 Day Elimination Period $ _____ ☐ Step Premium ☐ Level Premium

Note: When you fill out the monthly income benefit you want in this question, do not include any existing disability coverage you may have. For example, if you currently have $3,000 of disability insurance and are applying for an additional $1,500 of coverage, indicate $1,500 only in the areas above which indicate the amounts applied for. Do not enter the total amount of coverage you will have after your application has been approved.

2. Options on monthly income benefit applied for. **Only available at time of initial application for the DisabilityGuard™ Insurance plan. See the DisabilityGuard™ Insurance plan sheet for details.** *Check if desired:*

☐ Cost of Living Adjustment Option

☐ Future Insurance Guarantee Option

☐ Retirement Protection Option (choose one of the two options)

☐ **Option A** $500 monthly contribution benefit
☐ Step Premium ☐ Level Premium

☐ **Option B** $1,000 monthly contribution benefit
☐ Step Premium ☐ Level Premium

(Option B is available only to applicants with annual incomes over $100,000, pre-tax, after business expenses)

Section 4 Office Overhead Expense (OOE) Insurance

The completion of this section will help calculate the amount of Office Overhead Expense coverage you require for your portion of expenses. Only expenses relating to dental practices are insurable.

1. Average Monthly Expenses for Professional Practices (your portion) in increments of $100:

Accounting Services $ _____

Interest on Loans, Depreciation/Rental $ _____

Business Insurance Premiums $ _____

Association Membership Dues $ _____

Rent/Mortgage Interest Payments $ _____

Employee Salaries and Benefits $ _____

(Do not include salary paid to yourself or any member of your profession or any income splitting with a family member)

Telephone, Internet Service, Answering Service, Pager $ _____

Utilities $ _____
(Electricity, Heat, Laundry, Office Maintenance)

Other customary and reasonable fixed expenses incurred $ _____

Please list: _____

Total All Items:

Your Portion of Total Average Monthly Overhead Expenses $ _____

Total coverage in force and applied for may not exceed this amount.

2. Number of employees:

Full-time _____ Part-time _____

3. Amount of insurance applied for (**not including existing coverages**) in increments of $100:

Elimination Period	Payment Option #1 (Reducing)	Payment Option #2 (Fixed)	Benefit Period	Options
14-Day	$ _____	$ _____	☐ 12-month **or** ☐ 24-month	☐ Future Insurance Guarantee ☐ Own Occupation
14-Day	$ _____	$ _____	☐ 12-month **or** ☐ 24-month	☐ Future Insurance Guarantee ☐ Own Occupation
30-Day	$ _____	$ _____	☐ 12-month **or** ☐ 24-month	☐ Future Insurance Guarantee ☐ Own Occupation
30-Day	$ _____	$ _____	☐ 12-month **or** ☐ 24-month	☐ Future Insurance Guarantee ☐ Own Occupation

4. I would like to add the following options to my existing Office Overhead Expense coverage (check):

Option	☐ Future Insurance Guarantee	☐ Own Occupation

Note: Own Occupation and Future Insurance Guarantee Options are available for an additional premium. See the Office Overhead Expense Insurance plan sheet for details.

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DECLARATION OF INSURABILITY

Section 5 DisabilityGuard™/Office Overhead Expense Insurance

For Quebec residents, please fill out this box only if detaching Section 5 (see note at the end of Section 5):

Name of Person To Be Insured:

Last First Middle or Middle Initial

Date of Birth: D D M M Y Y Y Y

Date Application Signed: D D M M Y Y Y Y

IMPORTANT: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests.*

***Genetic tests means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.**

TO BE COMPLETED BY THE PERSON TO BE INSURED

YOUR PERSONAL INFORMATION

	YES	NO
Have you: 1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason:	☐	☐
2. a) In the past 5 years, been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked:	☐	☐
b) Within the past 3 years, been charged with or convicted of two or more moving or traffic violations? (for example, speeding, failure to stop, seat belt violations, distracted driving, or failure to provide a breathalyzer sample) If yes, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province:	☐	☐
Do you have: 3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s):	☐	☐
4. **Within the next 12 months:** **Do you have:** a) Any travel plans for travel outside of Canada and the United States of America? If yes, give details including where, when, why and for how long:	☐	☐
b) Any expectation to change your country of residence? If yes, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing:	☐	☐
5. **Within the past 5 years:** **Have you:** a) Used any drugs for other than medical purposes, used marijuana, or been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug or alcohol type(s) and date(s) last used:	☐	☐
b) Been convicted of a criminal offense or are you currently charged with one? If yes, please provide details:	☐	☐
c) Declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge:	☐	☐

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Section 5 DisabilityGuard™/Office Overhead Expense Insurance Cont'd

Physician's Name: _____

Physician's address and telephone number: _____

Date, reason and result of last consultation, and if any treatment or medication prescribed: _____

_____

Height _____ ☐ ft/in ☐ m/cm Weight: _____ ☐ lb ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No If yes: Gained _____ ☐ lb ☐ kg Lost _____ ☐ lb ☐ kg

Reason for change: _____

YOUR FAMILY MEDICAL HISTORY

	YES	NO
1. Have any of your parents or siblings:		
a) Been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐	☐
b) Been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, or retinitis pigmentosa?	☐	☐

If you answered yes to question a) or b) above, please complete the following:

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death (if applicable) and Cause

YOUR MEDICAL INFORMATION

	YES	NO
2. Have you ever had any indication of or been treated for conditions involving any of the following:		
a) **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐	☐
b) **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐	☐
c) **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐	☐
d) **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐	☐
e) **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐	☐
f) **Your brain or nervous system**, such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐	☐
g) **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐	☐
h) **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐	☐
i) **Your blood or glands**, such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐	☐
j) **Your muscles, bones or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	☐	☐
k) **Your skin**, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐	☐
l) **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐	☐
m) **Cancer, cysts, lumps, polyps, or tumour**?	☐	☐
n) **Other illness or disorder not mentioned above** or, are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐	☐

Section 5 DisabilityGuard™/Office Overhead Expense Insurance Cont'd

	YES	NO
3. **If female**, a) are you currently pregnant?		
If yes, give due date, and the name and address of your obstetrician/gynecologist: _____	☐	☐
_____		
b) What was your pre-pregnancy weight? _____ ☐ lbs _____ ☐ kg		
c) Have there been any complications with your pregnancy? If yes, provide details: _____	☐	☐
_____		
4. **During the past 5 years, have you:**		
a) Been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain, sciatica, or other?	☐	☐
b) Had X-rays (including of the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐	☐
c) Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐	☐
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐	☐
5. **Have you been successfully vaccinated against Hepatitis B?**	☐	☐
If yes, provide date |_|_|_|_|_|_|_|_| D D M M Y Y Y Y		
If no, provide details_____		
_____		
6. **Within the past 2 years, have you:**		
a) Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐
b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐
c) Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐
d) Or are you currently unable to perform any of the usual duties of your occupation due to injury or sickness?	☐	☐

NOTICE ON EXCHANGE OF INFORMATION – **Must be detached, read and retained by the person insured**

Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Manulife or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (416) 597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. Information for consumers about MIB may be obtained on its web site at www.mib.com.

Plan underwritten by The Manufacturers Life Insurance Company

Section 5 DisabilityGuard™/Office Overhead Expense Insurance Cont'd

If you answered yes to any of the questions in the section titled Your Medical Information, please provide details in the table below. If more space is required, please attach a separate sheet (dated and signed):

YOUR MEDICAL INFORMATION DETAILS

Question Number	Nature of Disorder	Date and Duration	Treatment (if None, state "None") and Current Status	Attending Physician or Hospital

Quebec residents only: When your completed application is returned to CDSPI, Section 5 will be detached and sent to Manulife and no file copy will be retained at CDSPI's offices. However, you also have the choice of detaching Section 5 of this application and submitting it directly to Manulife. If you wish, you may complete the entire application and mail Section 5 only to the following address: ATTN: Affinity Markets Program Underwriting Department, Manulife, P.O. Box 670, Stn. Waterloo, Waterloo, Ontario N2J 4B8. All other sections of the completed application must be mailed to: CDSPI, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

This application will not be considered complete unless a properly completed, signed and dated Declaration of Insurability is received by Manulife.

Quebec residents: If you are detaching Section 5 and mailing it directly to Manulife, please complete the name of the person to be insured, their date of birth and the CDA membership number of the applicant listed in Section 1.

Name of Person To Be Insured:

Last First Middle or Middle Initial

CDA Membership Number(Applicant):

Date of Birth (Person To Be Insured): D D M M Y Y Y Y

Date Application Signed: D D M M Y Y Y Y

NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person insured.**

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 of Canada, and subject to the laws of those foreign jurisdictions. 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, Ontario N2J 4C6.

Access to information which you provide to CDSPI or CDSPI Advisory Services Inc. or which CDSPI obtains in its capacity as the administrator of the Master Agreement and/or group policy will be restricted to those employees, mandataries, administrators or agents of CDSPI or CDSPI Advisory Services Inc. who are responsible for the marketing and administration of services, and the facilitation of claims under the Master Agreement and/or group policy, and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at CDSPI or CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Road, Toronto, Ontario M3B 2T8.

Plan underwritten by The Manufacturers Life Insurance Company

Section 6 Financial Information of Person To Be Insured

Annual Earned Income consists of income earned by you in any and all occupations and/or from any business or professional practice (excluding unearned or investment income such as pensions, interest, dividends, etc.) after deducting business expenses, but before income taxes.

1. Date of the practice's fiscal year end: D D M M Y Y Y Y

2. Annual Earned Income	Current Year to Date	Last Year End	Year End – Two Years Prior
A. Your gross earned income (from all sources) including salary, fees, commissions and bonuses:	$	$	$
B. Less annual total of all your business expenses:	$	$	$
C. Net annual earned income after expenses and before taxes:	$	$	$

3. ☐ Sole Proprietor	☐ Partnership	☐ Associate	☐ An Employee (other than as an employee of your corporation)
☐ Corporation	If incorporated, give percentage of ownership: _____% If a shareholder employee of a professional corporation or a partner, give % of ownership:_____% Total number of partners, shareholders or associates in your practice: _____ If expenses are shared, what is your share?_____%		
☐ Self-Employed	If self-employed, since when: month_____year_____ If self-employed less than 2 years, provide details of your previous employment structure: _____ _____ _____ If self-employed, what % of income is coming from any occupation other than the practice of dentistry? _____%		

	YES	NO
4. In the next 12 months: Do you expect a change to your employment, financial or business structure set-up? If yes, provide details. _____	☐	☐
5. Does your unearned income (investments, interest, pension, etc.) exceed $30,000 or 15% of your total earned income? If yes, please provide amount of your unearned income for: Current Year_____ Prior Year_____ Source(s)_____	☐	☐
6. Are you eligible for employment insurance?	☐	☐

	YES	NO
7. Do you have any income which will become payable or continue should you become disabled? If yes, indicate annual amount $_____ Source(s)_____	☐	☐
8. Does your net worth exceed $5,000,000? (Net worth: assets minus liabilities other than personal use assets such as residence, automobile, jewellery)	☐	☐

PROOF OF INCOME: Applicable to DisabilityGuard™ Insurance

If your total coverage from all sources will exceed $4,000/month, please provide a copy of your last personal income tax return (a Notice of Assessment is not acceptable). If incorporated, also provide a copy of your last Corporate Financial Statement (all pages). If you are purchasing an existing practice, also provide a copy of the last Financial Statement (all pages) from the practice you are purchasing.

NOTE: If you are a dental specialist in your first 2 years of practice after graduating from a specialty program, no proof of income is required for up to $6,000/month total from all sources* for disability coverage.

PROOF OF EXPENSES: Applicable to Office Overhead Expense (OOE) Insurance

If your **total*** OOE coverage will exceed $4,000/month, please provide a copy of your last income and expense statement. The statement should be prepared by an accountant and reflect at least 6 months of income and expenses. If you are purchasing an existing practice, also provide a copy of the last Financial Statement (all pages) from the practice you are purchasing.

NOTE: If you are a dental specialist in your first 2 years of practice after graduating from a specialty program, no proof of expenses is required for up to $6,000/month total from all sources* for OOE coverage.

*Total all sources = All existing and applied for coverage with all companies, including Canadian Dentists' Insurance Program coverage.

Section 7 Other Insurance

Do you currently have in force or have you concurrently applied for any sickness or accident coverage (including disability coverage through your employer), Office Overhead Expense or Retirement Protection coverage, provided by Individual or Group Policies, or Employment Contracts/Partnership Agreements, other than through the Canadian Dentists' Insurance Program? ☐ Yes ☐ No If yes, please complete table below.

Insuring Company or Plan	Amount of Monthly Benefit ($)	Type of Coverage	Elimination Period	Benefit Period (e.g. 5 yrs., to age 65, etc.)	Taxable Benefit?	Are you replacing this coverage?
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

NOTE: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. In Quebec, a replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Plan underwritten by The Manufacturers Life Insurance Company

DECLARATION AND AUTHORIZATION

Section 8 — To Be Read, Signed and Dated By the Applicant (and Person To Be Insured if Other than the Applicant)

If this application is approved, the applicant will receive a certificate booklet containing a detailed description of coverage and limitations.

I apply to The Manufacturers Life Insurance Company (Manulife) for the insurance indicated above under the group policies issued in connection with the Canadian Dentists' Insurance Program.

I/We, the undersigned, declare that the statements contained in this application, including the statements in the Declaration of Insurability, are true and complete, and together with any other forms or documents signed or provided by me/us in connection with this application, form the basis for any Certificate of Insurance issued. I/We understand that any material misrepresentation at the time of application, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I/We understand that the insurance will take effect on the date the properly completed application is approved by Manulife, subject to the person to be insured being actively at work on that date and to payment of the first premium within 30 days of issuance of a premium invoice. I/We understand that any health information must be accurate as of the date the application is signed.

I/We acknowledge receipt of and confirm my/our agreement with the Notice on Privacy and Confidentiality and the Notice on Exchange of Information.

Relative to the insurance applied for, I, the Person To Be Insured, authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, MIB Group, Inc., 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 (including my accountant) that has any records or knowledge of me, my health or my finances to provide to Manulife or its reinsurers any such information for the purposes of this application and contract and any subsequent claim. I/We authorize Manulife to consult its existing files for this purpose. I/We declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I/We understand that 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. A photocopy or facsimile of this authorization shall be as valid as the original.

NOTE: Eligibility for coverage or increased coverage is limited to Canadian citizens or permanent residents of Canada who are members of the CDA or participating provincial or territorial dental associations (in Quebec, only CDA members are eligible).

Signature of Person To Be Insured (if other than the applicant) _____ Date D D M M Y Y Y Y _____ Signed at City/Town _____ Province/Territory

Signature of Applicant _____ Date D D M M Y Y Y Y _____ Signed at City/Town _____ Province/Territory

QUEBEC RESIDENTS ONLY: If you have chosen to send Section 5 directly to Manulife, please indicate the date you sent Section 5 to Manulife:

Date

D D M M Y Y Y Y

Manulife