Manulife

SMA SASKATCHEWAN MEDICAL ASSOCIATION

RESIDENT DOCTORS OF SASKATCHEWAN (RDoS)
Application for SMA Disability Insurance

Please PRINT clearly.

Part A – Applicant Information

☐ Male ☐ Female

Name (Last, First, Middle Initial)

DD/MM/YYYY

Place of Birth (Province and Country) Date of Birth

Residence Address (Street Number and Name, Apartment or Suite)

City/Town Province/Territory Postal Code

Telephone (Primary) Primary Email Address

Membership Number Specialty Program Year 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

☐ **Non-Smoker** ☐ **Smoker** Non-smoker rates apply to people who have not used any form of tobacco or tobacco cessation products in the last 12 months.

Part B – Amount Of Insurance Applied For

1. Select your base monthly coverage:

☐ Program Year 1 ($4,900) ☐ Program Year 2 ($5,400) ☐ Program Year 3 ($5,800)

☐ Program Year 4 ($6,300) ☐ Program Year 5 ($6,700) ☐ Program Year 6 ($7,200)

☐ Other Amount $___________________________ ☐ Non-Medical coverage ($2,500 only)

Note: Manulife reserves the right to reduce the monthly benefit at time of underwriting if the applicant has pending or existing disability insurance with Manulife or another carrier as disclosed in Part C - Other Information.

2. Select your optional riders:
(Note: The premium for these riders is not covered by RDoS and will be deducted through your payroll if added.)

Own Occupation Rider: ☐ Yes ☐ No Retirement Protection Rider: ☐ Yes ☐ No Amount $_____________________ (min. $300 max. $1500)

Waiting / Elimination Period

Injury = 0 days. Benefits commence on the 1st day for injury and are payable for the lifetime of the insured.

Sickness = 90 days. Benefits commence on the 91st day for sickness and are payable to age 65.

Note: No benefits are payable during the waiting period and benefits may be limited if the disability commences after age 63.

Part C – Other Information

Do you have any pending or existing disability insurance coverage with Manulife or any other company? ☐ Yes ☐ No

If yes, complete the following:

Name of Insurance Company	Amount of Monthly Disability Benefit	Taxable Benefits	Waiting Period	Benefit Period	Are you replacing this coverage?
a)	$	☐ Yes ☐ No			☐ Yes ☐ No
b)	$	☐ Yes ☐ No			☐ Yes ☐ No
c)	$	☐ Yes ☐ No			☐ Yes ☐ No
d)	$	☐ Yes ☐ No			☐ Yes ☐ No

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

Part D – Personal Information (This section must be completed if you are applying for any Optional Riders or for any amount over $2,500.)

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.

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.

Have you: YES NO

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 2 years, been charged with or convicted of 2 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 you answered yes to a) or b) above, please provide full details: nature of offence(s), date(s), driver's licence number and licensing province: ____________________
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. a) Within the next 12 months, any expectation to travel outside 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, 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: ____________________
6. Within the past 5 years, been convicted of a criminal offence or are you currently charged with one? ☐ ☐
   If yes, please provide details: ____________________
7. Within the past 5 years, declared, or are you contemplating, personal or business bankruptcy? ☐ ☐
   If yes, provide details including date of discharge: ____________________

Part E – Your Health Declaration (This section must be completed if you are applying for any Optional Riders or for any amount over $2,500.)

Please answer all questions and provide full details below, or attach a separate sheet, signed and dated.

Your regular treating physician's name: ____________________ Telephone number: ____________________

Address: ____________________

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

Height ________ ☐ ft/in ☐ cm Weight ________ ☐ lbs ☐ kg

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

Reason for change ____________________

MEDICAL INFORMATION

Have you ever had any indication of or been treated for conditions involving any of the following: YES NO

1. **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? ☐ ☐
2. **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other? ☐ ☐
3. **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? ☐ ☐
4. **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? ☐ ☐
5. **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other? ☐ ☐
6. **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? ☐ ☐
7. **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other? ☐ ☐
8. **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other? ☐ ☐
9. **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? ☐ ☐
10. **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? ☐ ☐
11. **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? ☐ ☐
12. **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? ☐ ☐
13. **Cancer, cysts, lumps, polyps, or tumour**? ☐ ☐
14. **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? ☐ ☐
15. If female: Are you currently **pregnant**? If yes, give due date and the name and address of your obstetrician/gynecologist: ☐ ☐
    ____
    a) What was your pre-pregnancy weight? ________ ☐ lbs ☐ kg
    b) Have there been any complications with your pregnancy? If yes, provide details:
    ____

	YES	NO
16. Have you been successfully **vaccinated against hepatitis B**? If yes, provide date:__________________ If no, provide details: __________________	☐	☐

If you answered yes to any of the above 16 questions, please give details below:

Question Number	Details

MEDICAL INFORMATION (CONTINUED)

During the past 5 years, have you:

		YES	NO
1.	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?	☐	☐
2.	Had X-rays (including of the spine or joints), an electrocardiogram (ECG), blood test or other diagnostic test?	☐	☐
3.	Been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐	☐
4.	Been hospitalized or been medically disabled for more than two consecutive weeks?	☐	☐
5.	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?	☐	☐

If you answered yes to any of the above 5 questions, please give details below:

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

Within the past 2 years, have you:

		YES	NO
1.	Had an abnormal mammogram, PSA or any other test or investigation?	☐	☐
2.	Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	☐	☐
3.	Been advised to undergo further investigation, see another doctor or have surgery?	☐	☐
4.	Or are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐	☐

If you answered yes to any of the above 4 questions, please give details below:

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

YOUR FAMILY MEDICAL HISTORY– Have any of your parents or siblings (brothers or sisters):

		YES	NO
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 and Cause, if applicable

Please detach and retain for your records.

Part H – 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.

Part F – Declaration and Authorization

I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife).

I declare that the statements contained in this application, including but not limited to the Health Declaration, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any certificate issued hereunder. I understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at any instance of the insurer. I understand that other exclusions and limitations will apply to the coverage applied for. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, MIB, Inc., any insurance company, agent, broker, market intermediary, plan sponsor, group policy administrator or third-party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me or my health, or the health of any member of my family to be insured under this plan, to provide such information to Manulife or its reinsurers for the purpose of this application, any certificate issued hereunder and any subsequent claim. I further authorize Manulife to consult this application and its existing files for this purpose. I understand that in connection with this application, Manulife may request a medical examination, urinalysis or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law.

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.

Coverage is effective the first day of the month following the date of approval of the written application including such evidence of insurability as the Company may require. The first premium is collected following approval and is not collected at time of application. If my application is approved, I will receive a certificate specifying the coverage provided and the main certificate provisions.

I acknowledge receipt of and agreement with the Notice on Privacy and Confidentiality and Notice of Exchange on Information.

A photocopy of this signed 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 ______________________________

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Part G – Notice of Exchange on Information

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, ON M5G 1R7. Information for consumers about MIB may be obtained on its web site at www.mib.com.