LEVINE
FINANCIAL GROUP

Medical Students Disability Insurance – Special offer

As a graduating medical student, you are eligible to enroll for up to $4,500 per month of *individually owned* disability insurance through RBC Insurance. **You can enroll with NO MEDICAL, receive up to a 40% discount* and up to 12 months FREE coverage!**

HIGHLIGHTS

- ✓ **Own occupation coverage**
- ✓ **Cost of living adjustment**
- ✓ **Future income option up to $25,000/month**
- ✓ **25-40% Annual premium discount**.
- ✓ **NO MEDICAL**
- ✓ HIV and Hepatitis B and C protection
- ✓ Conversion to long term care coverage
- ✓ Up to **12 MONTHS FREE** coverage!

WHAT DOES IT COST?

Please find below tables showing your initial monthly premium for $2,500 or $4,500 per month of disability insurance. Your plan includes the own occupation definition of disability, a cost of living adjustment, a future income option, HIV, HEP B&C protection, a conversion to long term care coverage and up to a 40% annual premium discount*

$2,500 per month of coverage		
	Monthly Rate	
Age	Male	Female
20 - 25	$35.48	$58.79
26	$36.85	$63.62
27	$37.77	$67.17
28	$38.83	$69.57
29	$40.05	$72.17
30	$41.45	$74.95
31	$43.05	$77.99
32	$44.77	$81.18
33	$47.00	$84.49
34	$49.55	$87.94
35	$52.36	$91.54

$4,500 per month of coverage		
	Monthly Rate	
Age	Male	Female
20 - 25	$60.39	$100.06
26	$62.72	$108.27
27	$64.27	$114.32
28	$66.08	$118.38
29	$68.15	$122.81
30	$70.54	$127.55
31	$73.25	$132.70
32	$76.17	$138.15
33	$79.98	$143.78
34	$84.32	$149.66
35	$89.04	$155.77

*Doctors under age 35 are eligible for a 40% discount off the initial premium; that levels off to a 25% premium reduction off the ultimate premium at a later age

If you are interested in enrolling for this special offer, please complete the enrollment form; attach a VOID and **scan and email your application and void cheque to info@levinefinancialgroup.com**

Feel free to contact us by email at info@levinefinancialgroup.com **or call 416-222-1311**

RBC Insurance

Medical Student Application for Disability Insurance

to RBC Life Insurance Company

(For use under the Medical Student Offer)

PROPOSED INSURED NAME		
Last	First	Middle Initial

PROPOSED INSURED ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBER	ALTERNATE CONTACT NUMBER	E-MAIL ADDRESS

DATE OF BIRTH			GENDER	LANGUAGE OF POLICY
Day	Month	Year	Male ☐ Female ☐	English ☐ French ☐

FULL NAME OF BENEFICIARY FOR SURVIVOR BENEFIT	RELATIONSHIP TO PROPOSED INSURED

UNIVERSITY or MEDICAL FACILITY NAME	CURRENT YEAR OF STUDY (Circle one)
	1 2 3 Final Residency[1] Fellowship[1]

[1] If in the final year of Residency or Fellowship and going into practice within 6 months, please indicate: ☐ Family Doctor or ☐ Specialist

QUESTIONNAIRE	YES	NO
1. Are you a Canadian Citizen or a Permanent Resident (landed immigrant)?	☐	☐
2. In the past 12 months, have you used any form of tobacco (other than one large cigar per month), betel nuts or leaves (more than once per month), e-cigarettes, water-pipe, nicotine products or smoking cessation products?	☐	☐
3. Are you now, or in the past 180 days, have you been unable to work or attend school continuously on a full-time (30 hours per week) basis in the usual and customary manner performing all of the duties of your occupation or studies, or have you been homebound more than 5 days and/or hospitalized due to an accident or sickness?	☐	☐
4. In the past 5 years, have you received any treatment, medical advice, been diagnosed with, required any follow-up for, or had any symptoms of: Depression, burn out, post-traumatic stress disorder, bipolar disorder, suicidal thoughts or attempts, hallucinations, psychosis, chronic fatigue syndrome, dysthymia, bulimia, anorexia nervosa, agoraphobia, fibromyalgia, chronic pain syndrome or are you currently taking any anti-depressant or anti-anxiety medication?	☐	☐
5. Has an insurance company ever denied you disability insurance under an individual, group or association plan?	☐	☐
6. Do you currently have the loss of: your power of speech, or your hearing in both ears, or sight in both eyes, or the use of both hands, or the use of both feet, or the use of one hand and one foot?	☐	☐

Please provide details of "YES" answer to question 6:

COVERAGE APPLIED FOR

PLAN NAME	BENEFIT AMOUNT	ELIMINATION PERIOD	BENEFIT PERIOD	OPTIONAL BENEFITS
The Professional Series® **Level Premium** ☐ **Step Rate Premium** ☐	**$**_____	**90 Days**	**To Age 65**	**Health Care Profession Benefit (mandatory)** **Cost of Living Adjusted Benefit** ☐ **Disability in Your Occupation Benefit** ☐ **Future Income Option (FIO)** ☐ **If FIO selected: FIO Unit of Increase $** _____

COMPLETE, SCAN AND EMAIL TO

INFO@LEVINEFINANCIALGROUP.COM

RBC Life Insurance Company
6880 Financial Drive, Mississauga, Ontario L5N 7Y5

7.	PLEASE COMPLETE THE FOLLOWING TABLE IF YOU HAVE ANY INDIVIDUAL, GROUP OR ASSOCIATION DISABILITY INSURANCE IN FORCE OR PENDING OTHER THAN THE COVERAGE BEING APPLIED FOR WITH RBC LIFE. IF THE TABLE IS LEFT BLANK, YOU ARE CONFIRMING THAT YOU HAVE NO OTHER DISABILITY INSURANCE IN FORCE OR PENDING (OTHER THAN RBC LIFE).				
	COMPANY	**AMOUNT OF MONTHLY BENEFIT**	**TYPE (GROUP, INDIVIDUAL, ASSOCIATION)**	**TAXABLE?**	**ARE YOU REPLACING THIS COVERAGE WITH THE COVERAGE APPLIED FOR IN THIS APPLICATION?**
				Yes ☐ No☐	
				Yes ☐ No ☐	

DECLARATIONS AND CONSENTS (Please review and sign)

It is understood and agreed as follows:

1) The Pre-Authorized Debit (PAD) form and a deposit for one month of premium are required in order to activate any coverage. If no deposit is being provided, I authorize RBC Life Insurance Company (RBC Life) to withdraw the initial premium by PAD;
2) I have read all the foregoing statements and answers. They are all true and complete. They are part of this application and any individual policy issued as a result.
3) No agent or broker has authority to waive the answer to any question, to determine insurability, to waive any rights or requirements, or to make or alter any contract or policy.
4) RBC Life may be entitled to render this policy null and void if there is misrepresentation or non-disclosure in any part of this application that is material to the insurance risk.
5) Any policy issued as a result of this form shall become effective on the Date of Issue provided that: (a) the policy has been tendered for delivery to the Proposed Owner; and (b) the answers provided on this application have not changed from the date of this application to the Date of Issue date; and (c) the initial premium required has been paid. I will immediately advise RBC Life in writing, of any changes in the answers to the questions in this application between the time of this application and the delivery of the policy.
6) If applicable, any policy issued as a result of this application shall be subject to a group/association offset amendment and/or a pre-existing conditions amendment (which contains a coverage exclusion based on my pre-existing health), and/or a travel exclusion (which limits coverage while travelling outside of Canada or the United States). If individual disability coverage is part of a Wage Loss Replacement Plan, the policy will include a Wage Loss Replacement Amendment.
7) I acknowledge that if I answered "yes" to question six (6), I will not be covered under the Presumptive Total Disability Benefit provision that is contained in the policy issued to me, for the specific condition(s) that require question six (6) to be answered "yes".
8) I acknowledge that if I answered "yes" to question four (4), any coverage issued will include an exclusion for any psychiatric or emotional disorder, including but not limited to depression, anxiety, stress, burn out or substance abuse, chronic fatigue syndrome, chronic pain syndrome or fibromyalgia. RBC Life will reconsider this exclusion five years from the Date of Issue. Removal of the exclusion is subject to an application at that time, evidence of insurability and RBC Life approval.
9) I understand that when RBC Life determines the amount of insurance coverage that it will issue, they will rely on the information I have given in Section 7 about any existing or pending disability coverage. I acknowledge that if I either do not discontinue coverage that I have indicated will be replaced or I have not disclosed all existing coverage (other than RBC Life), the benefits under this policy may be reduced or not provided at all.
10) The actual amount RBC Life will issue will be based on the maximum amount I qualify for, any other disability coverage in force or pending that is not being replaced or cancelled and RBC Life Issue and Participation Limits. RBC Life is not required to specifically notify me if the amount applied for and the amount issued is different.
11) RBC Life shall not be liable for any claim on account of any benefits applied for, commencing prior to the effective date of coverage. Notwithstanding any interim premium payments, no temporary or conditional insurance is being provided to either the proposed insured or the proposed owner.
12) Acceptance of any policy issued as a result of this application form will ratify my acceptance of any differences in the terms of coverage between the policy wording and as stated in this form.
13) I have read the section entitled "Collection and Use of Personal Information" appearing in this application and I understand and agree to its terms.

SIGNATURE:

Proposed Insured: _____ Date: _____
(Day, Month, Year)

SIGN HERE

Advisor Information (for RBC Life use only)

Date (dd/mm/yy)				
Advisor's Signature				
Advisor's Name	52014 - Levine Financial Group			
Advisor's Company Name				
Marketing Office / MGA				
Share	%	Servicing Advisor Code:	%	Advisor Code :

Pre-Authorized Debit (PAD) Agreement

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals to pay the premium in accordance with the premium schedule set out in this policy/policies, including the initial premium, against the account at the financial institution below, or any other financial institution that the Payor(s) may later designate.

   (b) **RBC Life is not required to provide notification before the initial premium is debited, or if the amount of withdrawal should vary.**

   (c) unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy/policies.

   (d) the financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premium or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account,

   (e) notification of any change to the information provided below, shall be given to RBC Life by the Payor(s), at a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor's oral or written instructions.

   (f) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Canadian Payments Association website at www.cdnpay.ca."

   (g) In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

   The Payor(s) has certain recourse rights if any debits do not comply with this agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.cdnpay.ca.

   (h) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAD with policy number(s) _____

3. Special Requests (withdrawals are limited between the 1st – 28th of the month) _____

Bank Information:

Please attach a sample cheque marked void (a line of credit account cannot be used).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number

Address _____

City _____ Province _____ Postal Code _____

Dated at _____ (city/province) this _____ day of _____ (month) _____ (year)

Print Name of Payor (Account Holder) _____

Print Name of Second Payor (Account Holder) (if any) _____

Signature of Payor **SIGN HERE** _____

Signature of Second Payor (if any) _____

COMPLETE, SCAN AND EMAIL TO INFO@LEVINEFINANCIALGROUP.COM