Manulife

OMA Ontario Medical Association

Send completed form to:

Manulife
P.O. Box 17001, Stn Waterloo
Waterloo, ON N2J 0G5

For more information, visit:
omainsurance.com

For questions, please call:
1-888-596-8881

Request for change to existing group insurance coverage

For the members of the Ontario Medical Association (OMA), and Atlantic Medical Associations or Societies (PTMA). In this form, *we, us,* and *our* refer to The Manufacturers Life Insurance Company (Manulife). *You, your,* and *I* refer to the plan member.

1 Member information

Residents of Quebec are not eligible for coverage.

OMA member ID #	PTMA member ID # (if applicable)	Policy #

Last name	First name	Middle initial

Former name (if applicable)	Sex	Date of birth (dd/mmm/yyyy)
	◯ Male ◯ Female	

Home address (street number and name)	Apartment or suite

City/Town	Province	Postal code

Telephone (preferred contact)
◯ Home ◯ Business ◯ Cell ( )

Email (optional) By providing us your email you are authorizing us to communicate with you by email for business purposes.

2 Type of change request

Use this section to request changes to your current coverage. Please use the Special instructions box to indicate details.

This form can't be used for requests to increase coverage, changes to non-smoker, adding dependents (spouse and/or children), reconsidering exclusions, or requesting to reinstate your policy.

Changes to your coverage. Use the Special instructions box to indicate details.

◯ Change premium payment method or frequency. Please complete section 5.

◯ Name change. Please complete section 4.

◯ Remove a spouse and/or dependent children.

Names of spouse and/or dependent children you are removing. _____

◯ Reduce coverage amount on policy number: _____ from $ _____ to $ _____

◯ Remove policy riders. Please use the Special instructions section below to indicate rider details.

◯ Increase elimination periods to: ◯ 30 ◯ 60 ◯ 90 ◯ 120 ◯ 180 ◯ 365 days

◯ Change from Health Plus to Health.

◯ Change from Dental Plus to Dental.

◯ Other. Please provide details in the Special instructions box.

Special instructions

Change date:

Please indicate a current or future date, do not back date. Changes will be effective on the requested date, or the last day of the requested month, whichever is later, provided a minimum of 31 days' notice is given. If a premium is withdrawn in the meantime, a premium adjustment may apply.

Date (dd/mmm/yyyy)

In addition to this request, are you requesting any changes to your existing insurance coverage with form AF1533E, *Application for change for OMA Critical Illness or Disability Insurance plans*?

◯ Yes ◯ No

2 Type of change request (continued)

Note, a minimum amount of Member Life coverage may be required in order to keep a Spouse Life plan active. Please refer to the terms of your contract for details.

Policy numbers

- For Health, Dental and OPIP policies, your plan number can be found on the front of your Benefit card.
- For all other policies, you policy number can be found on your Certificate.

Please indicate each policy number you wish to change.

Member Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Spouse Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Disability	◯ 2718	◯ 59997	◯ 17849	◯ 140004
Member Critical Illness	◯ 17862			
Spouse Critical Illness	◯ 17862			
Professional Overhead Expense	◯ 20647	◯ 20638		
Accidental Death and Dismemberment	◯ 95001			
Health/Health Plus	◯ 17884 Plan number:_____ ID number:_____			
Dental/Dental Plus	◯ 17884 Plan number:_____ ID number:_____			
OPIP (all coverage under OPIP will be changed)	◯ 50130/50131 Plan number:_____ ID number:_____			

3 Reason for change

Please indicate why you wish to change your coverage. Provide any additional details in the space provided.

◯ Cost of coverage
◯ My needs have changed. Please provide details below.
◯ Plan features/service. Please provide details below.
◯ I have obtained new coverage through:
- ◯ My employer
- ◯ Another insurance company
- ◯ Another medical association

Details/comments

4 Name change

Submit the appropriate legal documents if:

- the given name or surname changed for reasons other than marriage, divorce, or adoption
- a company changed its name.

Example:

- Certificate of Amendment
- Supplementary Letters Patent

No documentation is required if the name changed due to marriage, divorce, or adoption.

You are requesting to change the name of the:

◯ Insured person ◯ Policy Owner ◯ Spouse and/or dependent child

From

To

Reason for change:

◯ Marriage ◯ Divorce ◯ Adoption ◯ Other _____

5 Payment information

Select the payment method and frequency you want to use.

A $25.00 fee may be charged for all NSF (Non-Sufficient Funds) transactions.

1. **Select payment method**

◯ Credit card - To add or change your credit card payment, please call our Customer Service Centre at 1-888-596-8881. Your credit card expiry date is automatically updated, no action is necessary.

◯ Pre-Authorized Debit (PAD) - Complete questions 2, 3, 4, and 5.

2. **Select payment frequency**

◯ Annually

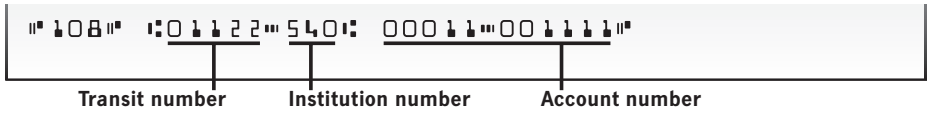
◯ Monthly, 1st of each month - Based on annual premium divided by 12 - no additional cost

3. **Your banking information**

◯ I authorize Manulife to use my existing PAD bank information from my current OMA insurance.

OR

◯ I authorize Manulife to use my bank information as follows:



Your Transit #	Institution #	Account #

4. Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payors' name (first and last) or full legal name of corporation/entity			
If applicable, date of birth (dd/mmm/yyyy)	Relationship to you		
Address (street number and name)		Apartment or suite	
City/Town	Province	Country	Postal code

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Non-chequing accounts: Approval from the financial institution is required for pre-authorized payments from accounts with no chequing privileges, so prior arrangements have been made to allow for pre-authorized payments from the account. Enclosed is a withdrawal slip that has been stamped by the financial institution allowing withdrawals to be made from the non-chequing account.

Payment authorization for PAD payment options

You authorize Manulife to collect the monthly or annual premium (including applicable provincial tax) for this insurance through PAD. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services as defined by Payments Canada in Rule H-1. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. You agree to waive the requirement that Manulife notify you of any payments after the first payment whether the amount of the monthly/annual premium is changed or not. You understand that the monthly premium is due the first of each month and annually on September 1st. This PAD agreement will be cancelled automatically if Manulife is unable to make a withdrawal from your account. This authorization is to remain in effect until Manulife has received written notification from you of its change or termination. This notification must be received at least 10 business days before the next debit is scheduled. You understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment. You may obtain a sample PAD cancellation form or more information on your right to cancel a PAD agreement at your financial institution or by visiting payments.ca. Manulife may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days' prior written notice to you. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. For more information about your recourse rights, contact your financial institution or visit payments.ca.

For further information about this authorization, contact:
Manulife
P.O. Box 17001, Stn Waterloo, Waterloo, ON N2J 0G5
Telephone: 1-888-596-8881

5. **Account holders – Please complete and sign**

Account holder name (full name or corporation/entity name)	Account holder address, if different from applicant
Signature of account holder (if business, authorized person to sign and indicate title) ✘	Date signed (dd/mmm/yyyy)
Joint account holder last name	Joint account holder first name
Signature of joint account holder (if both signatures required) ✘	Date signed (dd/mmm/yyyy)

6 Declaration and authorization

By signing below I authorize Manulife to process the requested changes outlined above. I understand the implications of the changes requested and that Manulife requires at least 10 business days to process coverage requests. All changes are made effective as of the end of the month in which the request is received or the requested date, whichever is later. Once the request has been processed, any premiums owing to me will be refunded, if applicable.

Signature of policy owner ✘	Date (dd/mmm/yyyy)
Signature of life beneficiary (if irrevocable) ✘	Signature of assignee (if collaterally assigned) ✘

The Manufacturers Life Insurance Company (Manulife)