



## Consent to Sharing of Information

For the purposes of this document, “I”, “me”, and “my” refer to the Applicant and, if signed by the Spouse, the Spouse, both jointly and severally.

### **Sharing of information**

I authorize OMA Insurance Inc.(OMAI), to share my personal (non-medical) information with MD Financial Management Inc. and its subsidiaries (MD), including MD Insurance Agency Limited and MD Management Limited, and with insurance companies with whom they are authorized to do business. This includes personal and financial information collected for the purposes of providing insurance and financial products as well as any ongoing decision(s) made respecting my insurance application(s) but excludes information relating to the reason for any decline(s). This information can be used for the purpose of administration, servicing the policies and providing me with additional products and services.

I also authorize OMAI, to share with MD, and the insurance companies with whom they are authorized to do business information on the type and status of the underwriting requirements, excluding the results of any such underwriting requirements. This information is used for the purpose of administering and servicing my application for insurance coverage.

I understand that where my personal information is shared with the insurance companies listed below or MD, it will be used in accordance with their Privacy Policies. For any questions regarding this, I should contact my OMA Insurance Advisor. The MD Financial Management Privacy Policy can be found on the website at <http://mdm.ca/privacy/index.asp>.

### **Sharing information within the OMAI**

All personal information collected by my OMA Insurance Advisor can be shared in accordance with the OMA Insurance Inc. Privacy Policy, a copy of which can be provided by any OMA Insurance Advisor or can be found on the website at <http://www.omainsurance.com/Pages/Privacy-Statement.aspx>. The list of companies with whom OMA Insurance does business can be found at <http://www.omainsurance.com/Documents/ConsenttoSharing-ListofCompanies.pdf>.

OMAI may use my personal information to process policy applications, communicate with me, including by telephone and email, and effectively provide the products and services I request and those OMAI believes might suit my current or future needs. Where OMAI collects personal information pertaining to two or more clients in respect of the operation of a joint policy, policy information which may include the personal information pertaining to one joint policy owner (excluding medical information) may be disclosed to the other joint policy owner without the permission of the person in respect of whom the personal information has been collected.

I understand that I may refuse to give the consent contemplated in this form and I may at any time withdraw this consent by providing direction to OMAI in writing. Where authorization to share certain types of information has been provided through separate documentation, additional withdrawal of consent to sharing will be required. In the event OMAI receives a request to withdraw consent, OMAI will inform all parties impacted by the withdrawal of consent in a timely manner. I have read and understood the contents of this document and I hereby consent to the sharing and use of my personal and financial information as indicated above.

A photocopy or electronic version of this authorization is as valid as the original and the authorization to share information shall remain in effect as long as coverage remains in force.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Signature  
(If applying for coverage): \_\_\_\_\_

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

### Consent to Sharing of Medical Information

For the purposes of this document, "I", "me", and "my" refer to the Applicant and, if signed by the Spouse, the Spouse, both jointly and severally.

#### **Sharing medical information**

I hereby authorize the insurance companies with whom I have concurrent applications to share any medical information submitted by me in connection with my application(s) for coverage. This medical information can be used by the relevant insurers in connection with my pending applications for insurance coverage underwritten by them.

A photocopy or electronic version of this authorization is as valid as the original and shall remain in effect pending a decision being made under my application(s) for insurance coverage as identified as above.

I have read and understood the contents of this document and I hereby consent to the sharing and using my personal and financial information as indicated above.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Signature  
(If applying for coverage): \_\_\_\_\_

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