# Application to Exercise Guaranteed Disability Insurability Benefit Option

OMA INSURANCE

Sun Life Financial

Coverage to be issued under Ontario Medical Association Group Disability Policy 59997

In this application *you* and *your* refer to the person applying for insurance. *We* and *the Company* refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Ref. number as shown on your letter

## A General information

Please PRINT clearly in ink.

Send correspondence to:
☐ Residence address
☐ Business address

| Last name | First name | Middle initial | ☐ Male ☐ Female | Date of birth (dd-mm-yyyy) |
|---|---|---|---|---|
| | | | | – – |

| Residence address (street number and name) | Apartment or suite |
|---|---|
| | |

| City | Province | Postal code | Telephone (residence) |
|---|---|---|---|
| | | | – – |

| Business address (street number and name) | Apartment or suite |
|---|---|
| | |

| City | Province | Postal code | Telephone (business) |
|---|---|---|---|
| | | | – – |

| Telephone (cell) | Fax | E-mail address |
|---|---|---|
| – – | – – | |

In which provincial medical association/society are you a member for insurance eligibility?
☐ OMA ☐ DNS ☐ NBMS ☐ NLMA ☐ MSPEI

Have you used tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the last 24 months?
☐ Yes ☐ No

## B Coverage information

Residents can apply to exercise the 2016 option if they currently have less than $3,500 monthly benefit in force with the OMA or less than $4,000 from all sources (excluding PARO, PAIRN or PARI-MP coverage).

1. Amount of additional monthly benefit applied for: (in $100 units)*:
   *up to $2,500 available if age 45 and under
   *up to $1,500 available if age 46 to 55
   $

2. Elimination period desired**:
   ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days
   **For the GIB option, the Elimination Period (EP) cannot be shorter than the EP you already have in force.

## C For residents only

1. a)

| Location of your post graduate program: hospital (city) | Province |
|---|---|
| | |

| Type of program (specialty) |
|---|
| |

b) Date you began current program: dd-mm-yyyy – –

c) Date your current program is due to be completed: dd-mm-yyyy – –

DC-100



Reference code 08-411

## D Practice information

1. a) Medical specialty:

   Date first commenced practice in specialty: dd-mm-yyyy

   b) Are you currently working at least 25 hours per week? ☐ Yes ☐ No

   c) Average number of hours worked per week: If less than 25 hours, please explain:

   d) Average number of weeks worked per year: If less than 46, please explain:

   e) Have you changed your job duties, location of practice and/or hours of work in the past 2 years, or do you contemplate such changes within the next year? ☐ Yes ☐ No

   If "Yes", please explain:

2. Please indicate your business structure:

   ☐ Sole owner ☐ Partnership ☐ Employee ☐ Associate ☐ Corporation % ownership

3. Net earned income (gross revenue less business expenses).

| Last year | Previous year |
|---|---|
| $ | $ |

4. a) If you are incorporated, please state your salary: $

5. b) If you are an employee (other than through your corporation), please state your salary:

   $ and employer's name:

## E Information on any other disability insurance

1. Do you currently have disability insurance in force or have you concurrently applied for any disability income coverage, including with your employer (other than OMA Insurance)? ☐ Yes ☐ No

   If "Yes", please provide details below:

| Amount of monthly benefit | Insuring company | Indicate if individual or group/association | Date of issue (dd-mm-yyyy) | Benefit period (e.g. to age 65) | Taxable benefits |
|---|---|---|---|---|---|
| $ | | | | | ☐ Yes ☐ No |
| $ | | | | | ☐ Yes ☐ No |

2. If "Yes" to 1, will any disability coverage be discontinued if this application is approved? ☐ Yes ☐ No

   If "Yes", please indicate the Insuring Company and Amount below:

| Insuring company | Amount |
|---|---|
| | $ |

## F Other information

1. Are you now disabled from performing the duties of your occupation and/or on claim and/or satisfying an elimination period? ☐ Yes ☐ No

   If "Yes", please indicate the date you became disabled: dd-mm-yyyy

   (Note: Any amount approved during a period of disability will apply only to any new disability.)

2. Have you ever declared, or are you contemplating bankruptcy? ☐ Yes ☐ No

   If "Yes", please indicate date of discharge: dd-mm-yyyy

3. Please indicate any unearned income in excess of $10,000 per annum (e.g., investment income not dependent on ability to work – not including RRSPs)

| Amount of unearned income | Source (securities, bonds, real estate, etc.) |
|---|---|
| $ | |

4. Does your net worth exceed $4,000,000? ☐ Yes ☐ No

   If "Yes" please indicate total amount: $

   Asset type (cash, stocks, bonds, real estate, etc.):

5. Do you have any income that will continue under a partnership arrangement or employment contract, should you become disabled? ☐ Yes ☐ No

   If "Yes", please provide amount and details in the space provided below:

## G Declaration and authorization

I declare that my answers in this Application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Application will cause the insurance to be void. As a member of the Ontario Medical Association, Newfoundland and Labrador Medical Association, New Brunswick Medical Society, Medical Society of Prince Edward Island, or Doctors Nova Scotia, I understand and agree that (a) if issued, the Option Amount will become effective on the date the application is received by OMA Insurance, but not earlier than May 1st, 2016, provided the application is received no later than May 31st, 2016; (b) the new Certificate will have the same exclusion(s) as specifically excluded from the Guaranteed Insurability Benefit Option rider under the Certificate and (c) the new Certificate shall be subject to the terms of the Rider under which this option is being exercised. I authorize Sun Life Assurance Company of Canada, the OMA as plan administrator and their agents, and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance coverage.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage.

| Signature of applicant | Date (dd-mm-yyyy) |
|---|---|
| X | |

Forward your completed application to:

OMA Insurance
PO Box 365, STN Waterloo
Waterloo, ON N2J 4A4
or Fax to: 1-800-367-0813

## H Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with insurance products that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.