OMA INSURANCE

Application for Disability and/or Professional Overhead Expense Insurance

Sun Life Financial

Policy numbers:
17849 / 20647

Clear

Please PRINT clearly in ink.

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.

1 Member information

Ref # (if known)

Last name	First name	Middle initial	☐ Male ☐ Female
Former/maiden name (if applicable)		Date of birth (dd-mm-yyyy) – –	
Province of birth	Country of birth		
Residence address (street number and name)		Apartment or suite	
City	Province	Postal code	
Office address (street number and name)		Apartment or suite	
City	Province	Postal code	

Have you used tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the last 24 months?

☐ Yes ☐ No

2 Contact information

In order to complete your application, Exam One on behalf of Sun Life will contact you to ask about your medical history.

Please indicate your contact information.

Telephone (residence) – –	Telephone (office) – –	Telephone (cell) – –
Email address		

Best time and number to reach you.

Phone
- ☐ Residence
- ☐ Office
- ☐ Cell

Monday to Friday
- ☐ Morning (8:00–12:00)
- ☐ Afternoon (12:00–5:00)
- ☐ Evening (5:00–8:00)
- ☐ Night (8:00–10:00)

Saturday
- ☐ Morning (10:00–12:00)
- ☐ Afternoon (12:00–4:00)

DC-100

Source code

3 Coverage applied for

a) Disability insurance (DI)

Minimum $500
Maximum $25,000
(from all sources)

You may select one or more elimination periods.

Amount of insurance applied for in increments of $100		
$ 30 days	$ 60 days	$ 90 days
$ 120 days	$ 180 days	$ 365 days

Sun Life will underwrite your application for the maximum amount of coverage appropriate to your income level. You may be offered additional coverage with the understanding that you can refuse it and only take the amount applied for on this application.

b) DI riders – please select

☐ Own Occupation
☐ Guaranteed Insurability Benefit
☐ COLA
☐ Retirement protection
Select monthly amount:
☐ $500 ☐ $1,000 ☐ $1,500

Note: If you do NOT check a box, we will not consider the above rider(s) if it is not already in force.

c) Indicate the type of DI premium rate desired

☐ Step ☐ Level

Note: If you do NOT check a box, we will consider the premium rate as Step.

d) Professional Overhead Expense (POE) insurance

Minimum $500
Maximum $30,000

You may select one or more elimination periods.

Amount of insurance applied for in increments of $100	
$ 14 days (Maximum $6,500 if applying for 14-day elimination period)	$ 30 days
$ 60 days	$ 90 days

e) POE rider – please select

☐ Guaranteed Insurability Benefit

f) Special Life Insurance offer

☐ I wish to be considered for Group Term Life insurance from New York Life Insurance Company. I agree that Sun Life Assurance Company of Canada may use the information received in connection with this application for disability coverage to determine if I am eligible for coverage *without any additional medical evidence of insurability*. I further agree that if I am offered life insurance and I accept the offer, I authorize New York Life and their agents and service providers to collect and use such information for the administration and adjudication of claims for such coverage.

4 Insurance information

***Note:* Do not cancel any existing coverage until the coverage you have applied for has been approved.**

Other than any OMA, PARO, Maritime Resident Doctors or PAIRN insurance, do you currently have or have you concurrently applied for any disability income or overhead insurance?

☐ Yes If *yes*, please provide details below.
☐ No

Amount of monthly benefit	Type of coverage (DI or POE)	Insuring company	Date of issue (mm-yyyy)	Are benefits taxable?	Indicate if any coverage will be discontinued if this coverage is approved.
$			–	☐ Yes ☐ No	☐ Yes ☐ No If *yes*, amount. $
$			–	☐ Yes ☐ No	☐ Yes ☐ No If *yes*, amount. $

5 For Members currently insured under the Group Disability Policy 2718, 59997 and/or 17849

Coverage under policy 2718, 59997 and/or 17849 will be terminated or reduced effective on the end of the day prior to the effective date of coverage being approved under this application.

Indicate below *only if you wish to terminate and/or reduce coverage* under Group Disability Policy 2718, 59997 and/or 17849:

a) **Terminate all coverage under:** ☐ 2718 ☐ 59997 ☐ 17849 on approval of this application.

b) **Reduce coverage to:** ☐ 2718 $ (in units of $100 to a minimum of $500)

☐ 59997 $ (in units of $100 to a minimum of $500)

☐ 17849 $ (in units of $100 to a minimum of $500)

By not checking a box above, you agree to maintain your existing coverage.

6 Occupational information

a) In which provincial medical association/society are you a member for insurance eligibility?
☐ OMA ☐ DNS ☐ NBMS ☐ NLMA ☐ MSPEI
(If you are not a member, please contact your provincial medical association/society to arrange for membership.)

b) Are you practicing medicine in a Covered Province?
☐ Yes ☐ No If *yes*, provide date you began. Date (dd-mm-yyyy) Province

c) Medical specialty

d) Date first commenced practice in specialty and where. Date (dd-mm-yyyy) Province Country

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

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

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

h) Do you have a valid and unrestricted license to practice medicine in a Covered Province?
☐ Yes ☐ No If *no*, please explain:

i) Do you expect to change your country of residence or have extended period(s) of travel outside Canada within the next 12 months?
☐ Yes ☐ No If *yes*, please explain:

7 Financial information

Physicians in their first two years of practice applying for coverage amounts of up to $7000 for General Practitioners and $10,000 for Specialists do not need to complete this section.

a) Please indicate your business structure:

☐ Sole owner ☐ Partnership ☐ Corporation
☐ Associate ☐ Employee

State your % of ownership: %

b) If any portion of your income is from a salaried position, please provide your salary:

$

c) Net annual earned income (gross income less business expenses)

Current year-to-date	Actual previous year
$	$

d) Please indicate any unearned income in excess of $10,000 per annum (investment income not dependent on ability to work, not including RRSP's)

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

e) Have you ever declared, or are you contemplating bankruptcy?
☐ Yes ☐ No If *yes*, please indicate date of discharge.

Date (mm-yyyy) – –

f) Does your net worth exceed $4,000,000?
☐ Yes ☐ No If *yes*, please indicate amount and asset type:

$

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

g) Do you have any income which will continue under a partnership arrangement or employment contract, should you become disabled?
☐ Yes ☐ No If *yes*, please provide the amount and details in the space provided below.

Amount	Details
$	

8 Financial documentation

The following documentation will be required depending on your financial reporting situation.

If applying for DI insurance, financial documentation is required to confirm your income unless you commenced practice within the last two years in Canada.

DI insurance

Employee (Salaried)	Sole Proprietor or Partnership	Incorporated
• Most current T4 • Income Tax Return (Pages 1 to 4)	• Income Tax Return (Pages 1 to 4) • Statement of Business or Professional Activities (T2125)	• Most current T4 • Personal Income Tax Return (Pages 1 to 4) • Business Financial Statements of the Corporation

If applying for POE insurance, financial documentation is required to confirm your expenses when POE insurance exceeds a total of $10,000 per month.

POE insurance

Sole Proprietor or Partnership	Incorporated
• Statement of Business or Professional Activities (T2125)	• Business Financial Statements of the Corporation

☐ I am enclosing the required documentation, **or**

☐ Please contact my accountant to obtain the required income documentation:

Accountant's name	
Address	
Telephone number – –	Fax number – –
Email	

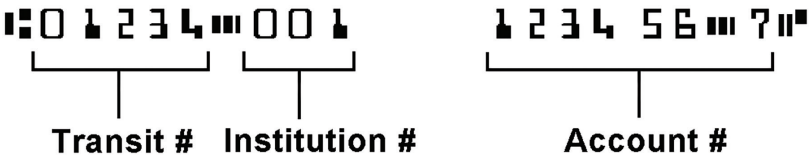
9 Request for pre-authorized debit (PAD) option

There are no additional charges for paying on a monthly basis – the annual premium is simply divided by 12 months.

Payment options

☐ Annually, 1st of September

☐ Monthly, 1st day of the month



Your Transit #	Institution #	Account #

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.

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

Authorization

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:

Terms and conditions

You authorize the OMA Insurance/Group Plan Administrator to collect the annual or monthly premium (including applicable provincial tax), depending on your selection above, for this insurance through a Pre-Authorized Debit (PAD) from the account referenced on your enclosed blank cheque marked void. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for **personal** services. You acknowledge that the amount of the premium (including applicable provincial tax) collected through this agreement may vary, reflecting any changes, additions or deletions in plan coverage as well as premium rate changes. **You agree to waive the requirement that the OMA Insurance / Group Plan Administrator notify you of any payments after the first payment whether the amount of the monthly or annual premium is changed or not.** You understand that if you selected to pay your premium annually, payment will be due on September 1 each year. If you selected to pay your premium monthly, it will be due on the first day of each month. This agreement will be cancelled automatically if the OMA Insurance/Group Plan Administrator is unable to make a withdrawal from your account.

This authorization is to remain in effect until the OMA Insurance/Group Plan Administrator has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. 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 *www.payments.ca*.

The OMA Insurance/Group Plan Administrator 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. To obtain more information on your recourse rights, contact your financial institution or visit *www.payments.ca*.

9 Request for pre-authorized debit (PAD) option (continued)

For further information about this authorization, please feel free to contact the OMA Insurance/Group Plan Administrator at:
OMA Insurance
P.O. Box 365 Stn Waterloo
Waterloo, ON N2J 4A4
Telephone # 1-800-758-1641
email: *Can_AssocAndAffinity@sunlife.com*

Account holder(s) – Please complete and sign

Print account holder last name	Print account holder first name	
Signature of account holder (if business, authorized person to sign and indicate title) X		Date signed (dd-mm-yyyy) – –
Print joint account holder last name	Print joint account holder first name	
Signature of joint account holder (if both signatures required) X		Date signed (dd-mm-yyyy) – –

10 Declaration and authorization

* Residents of Quebec are eligible if 1) they practice outside of Quebec but still reside in Canada; 2) the Application form is signed in a province or territory other than Quebec; and 3) the certificate and all other communications will be delivered in a province or territory other than Quebec.

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application will cause the insurance to be void. As 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 this application is void unless I am in active medical practice or in medical training in Canada and reside in Canada* on both the date of this application and on the effective date of coverage.

I hereby certify that I have read and understood the Medical Information Bureau (MIB) notice in section 11, and I have, by my signature below, authorized the MIB to give to Sun Life Assurance Company of Canada or its reinsurers, any information it may have.

With respect to this application, I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose relevant information about me for the purposes of underwriting, administration and adjudicating claims with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers, and reinsurers and my accountant, and to collect, use and disclose information with OMA Insurance for the purpose of administration.

A photocopy or electronic version of this authorization is as valid as the original.

Signed at (city)	Signed at (province)
Signature of applicant X	Date (dd-mm-yyyy) – –

Reminder: In order to complete your application you will be contacted by Exam One on behalf of Sun Life to provide your medical history.

Please allow for scheduling this at your earliest convenience.

Return completed application to:

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

OMA INSURANCE

Application for Disability and/or Professional Overhead Expense Insurance

Sun Life Financial

Policy numbers:
17849 / 20647

Keep this for your reference

11 Medical Information Bureau notice

In the course of underwriting your application, Sun Life Assurance Company of Canada may disclose information about you to its reinsurers. Sun Life Assurance Company of Canada and its reinsurers may also release information in their files to other life and health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sun Life Assurance Company of Canada or its reinsurers may also submit a brief report of their findings to the Medical Information Bureau (MIB), a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If the person named in this application also applies for insurance coverage or submits a claim with another life or health insurance company that is an MIB member, MIB will, on request, supply that insurance company with the information on its files.

You may ask to see your personal information on file with MIB and correct anything that is inaccurate or incomplete.

You may write to the MIB at:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, ON M5G 1R7

or call: 416-597-0590

12 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

For your records

Date and sign:

- ☐ Section 9, Request for pre-authorized debit (PAD) option
- ☐ Section 10, Declaration and authorization

Return to our office:

- ☐ Page 1 to 6
- ☐ Financial documentation, if applicable
- ☐ Void cheque for pre-authorized debits

Date application was submitted (dd-mm-yyyy) _ _ _ _

Questions regarding your application can be made to our toll free number 1-800-758-1641.