Essentials Enrolment Form

Policy numbers
17849
20647
G-29500

Clear

No Medical Evidence Required

Group Disability and/or Group Professional Overhead Expense and/or Group Life Insurance for a medical resident/fellow.

Must be received by OMA Insurance within **120 days** of successful completion of your residency/fellowship program.
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.

Please PRINT clearly.

1 Member information

Ref. # (if known)

Last name	First name	Middle initial

Former/Maiden name (if applicable)	☐ 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)
			— —

Email address

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

Send correspondence to:
☐ Residence address
☐ Business address

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

If you plan to move within the next 6 months, please indicate your new address/phone information:

Residence address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone (residence)	Effective date of change (dd-mm-yyyy)
			— —	— —

Business address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone (business)	Effective date of change (dd-mm-yyyy)
			— —	— —

DC-122

Source code

2 Recently completed residency/fellowship information

a) Where did you complete or where are you completing your current residency/fellowship program? (province/state)

b) Date your current program was/will be completed — Date (dd-mm-yyyy)

c) Following the completion of your current resident program, will you be pursuing a Fellowship Program? ☐ Yes ☐ No

If *yes*, what is the start date? — Date (dd-mm-yyyy)

3 Coverage applied for

Essentials coverage available without medical evidence.

1. a) **Group Disability Insurance** – 90-day Elimination Period ☐ Yes — $
   Maximum up to $5,000 monthly benefit (from all sources).

   b) **Indicate the type of premium rate desired*** ☐ Step ☐ Level
   Note: If you do NOT check a box, we will consider the premium rate as Step.

   c) **Own Occupation Rider** ☐ Yes

   d) **Cost of Living Adjustment Rider** ☐ Yes

   e) **Disability Guaranteed Insurability Benefit Rider (GIB)**(must be under age 50) ☐ Yes

   f) **Retirement Protection Rider**
   The total amount of Retirement Protection Rider coverage cannot exceed $1,000.
   If you already have existing Retirement Protection Rider coverage, **please only indicate the additional amount being applied for**. ☐ Yes — $

2. a) **Group Professional Overhead Expense (POE)** – 30 day Elimination Period ☐ Yes — $
   Maximum up to $5,000 monthly benefit.

   b) **Professional Overhead Expense (POE) Guaranteed Insurability Benefit Rider** ☐ Yes

3. a) **Group Term Life Insurance for $100,000**** ☐ Yes
   Note: This offer does not include the optional waiver of premium benefit.

   If *yes* to 3 a), please complete 3 b) and 3 c).

   b) Beneficiary Designation – I hereby make the following beneficiary designation for my life insurance:
   (complete only if applying for Group Term Life Insurance under the Essentials plan)

Last name	First name	Middle initial

Relationship	Date of birth (dd-mm-yyyy) (if under age 18)
	— —

Please contact OMA for beneficiary changes on any existing Group Term Life insurance.

   c) Is your spouse also a physician? ☐ Yes ☐ No ☐ I do not have a spouse
   If *yes*, please provide the name of your spouse.

Spouse's last name	First name	Middle initial

***Step Rate** Premium automatically increases at ages 35, 45, and 55, starting the September following attainment of age. These increases are designed to keep costs lower during the early years when risk of becoming disabled is lower.

Level Premium Rates have been designed to remain level over time as you age and cannot be adjusted on an individual basis due to changes in your age or health. Level Premium Rates may change from time to time on a group basis depending on the insurance costs of the group.

** The total amount of non-underwritten OMA Life coverage under Policy G-29500, including OMA Student Life coverage in force cannot exceed $100,000. The amount of OMA Life insurance issued will be reduced by any other OMA Life coverage obtained without medical underwriting.

You may not be eligible for this offer if you are already insured as a spouse under this policy or under Policy G-29500 or G-29700 issued by New York Life.

4 Disability Guaranteed Insurability Benefit Rider Option for practising physicians and fellows

Complete only if you would like to exercise an option to increase your disability coverage.

1) Do you wish to exercise the Guaranteed Insurability Benefit option of up to a total amount of $7000/month as a General Practitioner or $10,000/month as a Specialist? ..... ☐ Yes

Indicate the total amount of coverage requested. ..... $

If *yes*, complete questions 2 to 6.

2) Have you obtained certification from either the College of Family Physicians of Canada (CFPC/CCFP) or the Royal College of Physicians and Surgeons (RCPSC)? ..... ☐ Yes ☐ No

If *yes*, please indicate which one: ☐ CFPC/ CCFP ☐ RCPSC

If *no*, please indicate below which certification you expect to receive and the date you expect to receive it:

☐ CFPC/ CCFP
☐ RCPSC

Date (dd-mm-yyyy) – –

3) Type of residency/fellowship program (specialty) most recently completed

4) Date you began/will begin practice of medicine or fellowship program

Date (dd-mm-yyyy) – –

5) Will you work at least 25 hours per week and 46 weeks per year in your medical practice or fellowship, within 120 days of completing your residency/fellowship? ..... ☐ Yes ☐ No

If *no*, please explain below. If you are on maternity or parental leave, please provide the date you will be actively at work full-time.

6) Are you now disabled and/or on claim and/or satisfying an elimination period? ..... ☐ Yes ☐ No

If *yes*, please indicate the date you became disabled

Date (dd-mm-yyyy) – –

5 For Members currently insured under Group Disability policy 59997 or 17849

Any group disability coverage under policy 59997 not being terminated or reduced will be increased with coverage under Essentials under policy 17849.

Complete if you would like to terminate or change existing coverage:
I would like to:

☐ terminate all coverage under my existing policy 59997 on approval of this application

☐ change my existing inforce OMA disability 60 day Elimination Period to 90 days

☐ replace GIB Rider under policy 59997 with policy 17849

6 Insurance information

1. Were you in the last 120 days (or are you currently) insured under a Long-Term Disability plan in Canada or the United States during your most current or recently completed residency/fellowship program?..... ☐ Yes ☐ No

If *no*, please explain

If you are still covered by your association for your second fellowship/residency, any Disability coverage approved under the Essentials offer will be offset by any Disability coverage you will have under your association.

2. a) Other than any OMA or resident association insurance do you currently have disability income insurance or have you concurrently applied for any disability income insurance? ..... ☐ Yes ☐ No

If *yes*, please provide amount and details below.

Amount of monthly benefit	Insuring company	Indicate Individual or Group/Association	Taxable benefits
$			☐ Yes ☐ No
$			☐ Yes ☐ No

b) If *yes* to a), will any disability income insurance be discontinued if this application is approved? ..... ☐ Yes ☐ No

If *yes*, please provide details below.

Company	Amount	Policy number
	$	

7 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

PLEASE ENTER YOUR BANKING INFORMATION IN THE SPACES PROVIDED.

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 1st 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*.

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) – –

8 Declaration and authorization

I declare that the answers in this Enrolment form are true and complete and I understand that concealment, misrepresentation or false declaration concerning this Enrolment form will cause this insurance to be void. I understand and agree that this Enrolment form is void unless: (a) I am a member of the Ontario Medical Association, Doctors Nova Scotia, New Brunswick Medical Society, Medical Society of Prince Edward Island, or Newfoundland and Labrador Medical Association, (b) reside in Canada, (c) the Enrolment form was signed in a province or territory other than Quebec and (d) the certificate and all other communications are delivered in a province or territory other than Quebec.

I understand that no coverage becomes effective unless this Enrolment form is received by OMA Insurance within 120 days of the successful completion of my residency/fellowship program (a) in Ontario as a member of PARO and PARO's group long term disability insurance plan, (b) under the Dalhousie University Program as a member of Maritime Resident Doctors and Maritime Resident Doctors's group long term disability insurance plan, (c) at Memorial University of Newfoundland as a member of PAIRN and PAIRN's group long term disability insurance plan or (d) any other resident association or group and their Long Term disability insurance plan. I understand that I am applying for Disability Insurance under Policy 17849 and/or Professional Overhead Expense insurance under Policy 20647 issued by Sun Life Assurance Company of Canada and/or Life insurance under Policy G-29500 issued by New York Life Insurance Company. Regarding the life insurance policy, for the purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada. Ontario Medical Association is the group policyholder under all policies. The effective date of my coverage will be the later of the following:

(a) The day following the date my residency/fellowship program terminates, if my completed Enrolment form is received within 120 days prior to the date I successfully complete my residency/fellowship program, or

(b) The date my Enrolment form is received, if my completed Enrolment form is received within 120 days after the date I successfully complete my residency/fellowship program, or

(c) Date member obtained membership after completion of residency/fellowship and after the date the application was received in our office.

If exercising my Disability Guaranteed Insurability Benefit option, I understand and agree that the option amount, if issued, will become effective on the later of the date I commence my fellowship/medical practice, or the date certification was obtained if obtained after commencing practice, or on the date this Enrolment form is received provided the form is received within 120 days of completion of a residency program and I have commenced my fellowship/medical practice.

I understand the insurance will become effective as described above if the required premium has been received by OMA Insurance within 45 days of the date I am billed.

With respect to this Enrolment form, I authorize Sun Life Assurance Company of Canada and New York Life Insurance Company and their 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 institutions, investigative agencies, insurers and reinsurers and to collect, use and disclose information with OMA Insurance for the purpose of administration.

I understand that any monthly Disability Income benefit provided under the OMA Policy will be reduced by the monthly amount of any disability income benefit that I receive or am entitled to receive under any Canadian or United States Resident Association insurance policy. No benefits will be payable for any disability that began prior to the effective date of my coverage. The amount of OMA Life insurance will be reduced by any other OMA Life coverage that was either obtained without medical underwriting or previously converted to an individual policy.

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

Please complete and sign your authorization.

Signed at (city)	Signed at (province)

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

Return completed and signed application to:

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

9 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*.