OMA INSURANCE

Application for Health and Dental insurance

Sun Life Financial

Policy number
17884

Ref. # (if known)

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/Employee information

Please complete all fields.

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

A. Are you applying as a member of an eligible association or as an employee of a member? (complete (i) or (ii))

(i) I am a member of ☐ OMA ☐ NBMS ☐ NLMA ☐ MSPEI

(ii) I am an employee of

Dr.

B. If you completed A (ii), how many hours per week do you work?

How many weeks per year do you work?

2 Benefit selection

Single plus one Dependent child: coverage for you and one dependent child

Couple: coverage for you and one family member (spouse or dependent child*)

Family: coverage for you and two or more family members (includes spouse and dependent children*)

1. Extended Health Care insurance (17884)

Choose only ONE of the following options.

☐ **Health**	☐ Single ☐ Single plus one Dependent child ☐ Couple ☐ Family
☐ **Health Plus**	☐ Single ☐ Single plus one Dependent child ☐ Couple ☐ Family

2. Dental insurance (17884)

Choose ony ONE of the following options.

☐ **Dental**	☐ Single ☐ Couple ☐ Family
☐ **Dental Plus**	☐ Single ☐ Couple ☐ Family

3 Dependent information

Complete if you checked Couple or Family coverage to provide information on the dependent(s) to be covered.

Spouse's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Student ☐ Yes ☐ No
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Student ☐ Yes ☐ No
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy)	☐ Male ☐ Female	Student ☐ Yes ☐ No

*A dependent child is your natural child, stepchild or legally adopted child who is not married or in any other formal union recognized by law:

Either of you or your legal spouse, who may or may not reside with you but is fully dependent on you for support; Or of you or your common-law spouse, who is in your care and custody, residing with you and being fully dependent on you for support; And is under age 18 (age 25 if a full-time student) or to any age if mentally or physically handicapped.

DC-100

Source code

4 Background information (if applying for Health or Health Plus coverage)

Do not complete if applying for dental coverage only.

You

Height: ft. in. m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg
Reason for weight change		
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)		
Name of physician, diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them		

Your spouse

Height: ft. in. m cm	Weight ☐ lbs. ☐ kg	Change in weight in the last 12 months ☐ No change ☐ Gain ____ ☐ Loss ____ ☐ lbs. ☐ kg
Reason for weight change		
Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)		
Name of physician, diagnosis, treatment given, results, medication prescribed		
If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them		

5 Family history information (if applying for Health or Health Plus coverage)

Do not complete if applying for dental coverage only.

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had cancer (specify type), heart disease, stroke, diabetes, polycystic or other kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), Muscular Dystrophy, familial polyposis of the bowel, Huntington's Chorea or any other hereditary disease?

☐ Yes ☐ No If yes, complete the chart below.

Your family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Your spouse's family history

	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

6 Medical and /or treatment information (if applying for Health or Health Plus coverage)

Do not complete if applying for dental coverage only.

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

You	Your spouse	Your dependent children
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If *yes* please complete the table below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time

7 Medical information (if applying for Health or Health Plus coverage)

	Member	Spouse	Dependents
Have you or your spouse or dependents ever:			
a) Had chest pain, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Had a stroke, transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Had diabetes; impaired fasting glucose, sugar, blood or protein in the urine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Had a disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or had any complications of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Had tumours, cancer, polyps or other growth; including breast lumps, cysts or other breast changes, or had an abnormal mammogram?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Had moles or other growth or a disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Had a blood or lymph gland disorder; leukemia or any other form of malignant disease; or had a biopsy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Had chronic lung or respiratory disorder; sleep apnea, disease or disorder of the eyes, ears, nose or throat or had loss of speech?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Had any disorder of the colon, rectum, intestines, including colitis or disorder of the stomach or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; fibromyalgia or rheumatic/arthritic disease; or lupus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Had any psychiatric disorder; depression, suicide attempts or ideations, anxiety state or panic attacks; eating disorder; other emotional or psychiatric disorder; or been counselled for such?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Had a disorder of the liver including testing positive for hepatitis B, hepatitis C or human immunodeficiency virus (HIV); been identified as a hepatitis B carrier or have chronic hepitatis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS) or any other immunological disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Had any other illness, disease, disorder, condition, injury diagnostic testing or surgical procedure not listed above; had any health symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you or your spouse or dependents ever:			
n) Consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If *yes*, please record the number of alcoholic beverages consumed in a week:			
Within the past 10 years, have you or your spouse or dependents:			
o) Received advice or treatment for the use of alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) Had a driver's licence suspended or ever been convicted for drunk or impaired driving, or had three or more speeding or moving violations in the last three years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) Used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
r) Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens,heroin, barbiturates, or sought or received advice or treatment for the use of drugs, prescribed or non-prescribed or obtained over the counter?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
s) Had critical illness insurance declined, postponed, rated, rescinded, cancelled or modified in any way, or ever been denied renewal or reinstatement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
t) Received disability benefits for three months or longer?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
u) Piloted or navigated any type of aircraft or do you engage or intend to engage in hazardous or extreme activities? e.g.: skydiving, hang gliding, scuba diving, mountain climbing, automobile or motorcycle racing, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you or your spouse or dependents replied yes to any of the questions (a-u), please provide details below. If the space provided is insufficient, please provide details on a separate, duly signed and dated sheet.

Question	Name of person	Date (dd-mm-yyyy)	Duration	Diagnosis	Treatment	Name and address of physicians, hospitals, insurance companies
		– –				
		– –				
		– –				
		– –				

8 Premium payments – pre-authorized debit (PAD)

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 January (Dental only)

☐ Monthly, 1st day of the month

⑆01234⑉001 1234 56⑉7⑈

Transit # | Institution # | Account #

Your Transit #	Institution #	Account #

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 January 1 each year. If you selected to pay your premium monthly, it will be due on the 1st 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 PAD 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.cdnpay.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.cdnpay.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)

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

9 Declaration and authorization

* Residents of Quebec are eligible if 1) they work 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 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, or as a spouse/employee of a member, I understand and agree that this application is void unless I 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 10, 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 needed 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 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.

Signature of member/employee		Signature of spouse (if applying for coverage)
X		X
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)
		– –

Please ensure you sign your completed application before sending to:
OMA Insurance
PO Box 365, STN Waterloo
Waterloo, ON N2J 4A4
or fax it along with a copy of your void cheque to:
1-800-367-0813
For more information or if you have any questions please:
call 1-866-527-9260 or 416-408-8420

10 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

11 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*.