Application for Plan Change under the Physician Health Benefit Program

delivered by OMA Priority Insurance Program (OPIP)

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

Please PRINT clearly in ink.

Section A: Applicant details and Coverage

1 Your 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 – –	Fax – –	Email address		

If you are age 65 and under, please indicate whether you are a non-smoker or smoker.

Have you used tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the last 12 months?
☐ Yes ☐ No

2 Applying for Changes to Government Subsidized PHBP Benefits

Please complete sections 3, 5, 6, 7 and 8 to provide information on yourself and any dependent(s) to be covered.

Please do not complete Section 2 if only applying for Self-funded options. Proceed to Section 4.

Current Coverage	Change Coverage to (for those under age 65)	Change Coverage to (for those over age 65)
A. Health Spending Account $500	☐ Critical Illness insurance $ 50,000* Health Insurance** OR ☐ Critical Illness insurance $ 50,000 Health Spending Account $350***	• Health Insurance**
B. Health Insurance	☐ Critical Illness insurance $ 50,000* Health Insurance OR ☐ Critical Illness insurance $ 50,000 Health Spending Account $350***	Not applicable
C. Critical Illness and Health Spending Account $350	☐ Critical Illness insurance $ 50,000 Health Insurance**	☐ Critical Illness insurance $ 50,000* Health Insurance**

D. ☐ **Add dependent spouse or child(ren) to existing Health Insurance coverage**
Please complete sections 3, 5, 6, 7 and 8 to provide information on any dependent(s) to be covered. If applying for self funded options, please complete Section 4.

E. ☐ **OPIP Continuation: apply for OMA subsidy**
To be completed by a member who was on OPIP continuation and becomes eligible for OMA subsidy. Please complete sections 9 to 12.
Member will be eligible to continue his/her in force coverage only.
Medical evidence may be required for any additional benefits requested.

*** Critical Illness (CI):** only available to members under age 65 who have not previously been declined for CI coverage or had a CI claim payout under any OMA Insurance Plans. CI coverage will terminate for members upon attaining age 70.

**** Health Insurance:** an applicant who was previously declined as a member or spouse/dependent under any OMA extended health care insurance may not be eligible for PHBP Health coverage.

***** Health Spending Account (HSA):** HSA is only available to members who have an equivalent extended health care insurance plan and wish to opt out of Health coverage.

Source code

For SLF use: DC-100

3 Dependent details

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

Check if you applied for Health Insurance in Section 2.

☐ Couple ☐ Member Plus one Dependent child ☐ Family

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

If you need more space, please complete on separate sheet of paper and sign and date it.

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.

4 Additional self-funded options

Monthly or Annual Premium are applicable/to be paid by member for self-funded options applied for.

PHBP Coverage selected in section 2	Additional coverage you can select
Critical Illness and Health	☐ Health Plus ☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family ☐ Dental*** ☐ Single ☐ Couple ☐ Family
Critical Illness and Health Spending Account $350	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family ☐ Dental*** ☐ Single ☐ Couple ☐ Family
Health	☐ Health Plus ☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family ☐ Dental*** ☐ Single ☐ Couple ☐ Family
Health Spending Account $500	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family ☐ Dental*** ☐ Single ☐ Couple ☐ Family

***Dental/Dental Plus – Policy 017884 No medical evidence required
Available to members under age 79

Section B: Personal health information (required as a late entrant for risk assessment)

5 Background information

Please provide details for person(s) applying for coverage.

Please do not complete if applying for Dental/Dental Plus 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		

Spouse (if applying for Spouse Health Insurance)

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		

6 Family history information

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 (if applying for Spouse Health Insurance)

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

7 Medical and/or treatment information

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

Source code

8 Medical information

		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
		– –				
		– –				
		– –				
		– –				

9 Payment information

Acknowledgement of OPIP annual contributions

I understand that the OPIP annual contribution is due on January 1st of each year

Payment selection for self-funded dental option

Select payment schedule if applying for additional self-funded dental options.

☐ Annually, 1st of January

☐ Monthly, 1st day of the month

Should you wish to pay your premiums on the 22nd of each month (payment applies to the month following), select here ☐

Same as current OPIP banking ☐

PLEASE ATTACH A BLANK CHEQUE MARKED VOID ACROSS THE FRONT, FROM A CANADIAN FINANCIAL INSTITUTION.

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 Sun Life Assurance Company of Canada (Sun Life) to collect the OPIP annual contribution under this benefits program 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 annual contribution collected through this agreement may vary, reflecting any changes, additions or deletions in plan coverage. **You agree to waive the requirement that Sun Life notify you of any payments after the first payment whether the amount of the annual contribution is changed or not.** You understand that the annual contribution is due on January 1 of each year. This agreement will be cancelled automatically if Sun Life is unable to make a withdrawal from your account.

If you selected additional self-funded options, you authorize Sun Life Assurance Company of Canada (Sun Life) 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 Sun Life 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 either the 1st or the 22nd day of each month, depending on your selection. This agreement will be cancelled automatically if Sun Life is unable to make a withdrawal from your account.

This authorization is to remain in effect until the Sun Life Assurance Company of Canada (Sun Life) 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 Sun Life Assurance Company of Canada (Sun Life) 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*.

9 Payment information (continued)

For further information about this authorization, please feel free to contact the Sun Life Assurance Company of Canada (Sun Life) 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 title) X	Date signed (dd-mm-yyyy) – –
Signature of joint account holder (if both signatures required) X	Date signed (dd-mm-yyyy) – –

10 Application for subsidy

Choose only one option.

1. ☐ **I am applying for the OMA subsidy**

I understand and acknowledge that the payment of Physician Health Benefit Program (PHBP) premium is my obligation and that this obligation, less my OPIP annual contribution, will be discharged by the subsidy provided through the Ontario Physicians Services Inc. (OPSI) to the Company. Furthermore, I understand and acknowledge that any subsidy provided through OPSI for my coverage under this benefits program may be considered income that must be reported by me for income tax purposes. Each year, to assist in that reporting, OPSI will issue a premium summary statement to me.

Your signature X	
Location signed (city)	Date (dd-mm-yyyy) – –

If your professional corporation is applying for the OMA subsidy, please provide your Corporation name.

2. ☐ **My professional corporation is applying for the OMA subsidy**

Corporation name

I understand and acknowledge that the payment of Physician Health Benefit Program (PHBP) premium is my professional corporation's obligation and that this obligation, less my corporation's obligation OPIP annual contribution, will be discharged by the subsidy provided through the Ontario Physicians Services Inc. (OPSI) to the Company. Furthermore, I understand and acknowledge that any subsidy provided through OPSI for the individual specified in Section A, 1 above, for coverage under this benefits program, may be considered income that must be reported by the corporation for income tax purposes. Each year, to assist in that reporting, OPSI will issue a premium summary statement to me.

Signature of signing officer X	
Location signed (city)	Date (dd-mm-yyyy) – –

11 Declaration and authorization

I declare that my answers in this application form are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application form will cause the insurance to be void.

I understand that to enrol in this benefits program I must be an *Eligible Physician*.

An Eligible Physician means a physician (excluding a resident) who:

1. **resides in Canada*;**
2. **is registered with the College of Physicians and Surgeons of Ontario;**
3. **is engaged in providing medical services in the province of Ontario for at least 15 hours per weekon average;**
4. **is a member in good standing of the Ontario Medical Association or, if not a member, has paid all dues and assessments owing under the *Ontario Medical Association Dues Act, 1991*.**

*Residents of Quebec are eligible if 1) they work in Ontario: 2) the application form is signed in a province or territory other than Quebec: and 3) they agree the certificate and all other communications will be delivered in a province or territory other than Quebec.

I understand that if I cease to be an Eligible Physician, I may continue to participate in this benefits program at my own expense, subject to age and certain other restrictions defined by the Program's contracts of insurance.

I hereby agree to advise the program administrator if I am no longer residing in Canada, if I am no longer registered with the College of Physicians and Surgeons of Ontario, if I am no longer engaged in providing medical services in the province of Ontario for at least 15 hours per week, on average, or if I am on a parental leave of absence for more than one year. I understand that if I have any questions about my ongoing eligibility to participate in this benefits program, I should contact the program administrator.

I hereby cerifiy that I have read the Medical Information Bureau (MIB) notice (see section 12), and having read the contents, I have, by the signature(s) below, authorized the MIB to give to Sun Life Assurance Company of Canada, or its reinsurers, any information it may have.

I authorize Sun Life Assurance Company of Canada and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigating agencies, insurers, and reinsurers and to use and exchange information with the Ontario Medical Association for the purpose of administration under this benefits program.

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

Your signature	Your spouse's signature
X	X

Location signed (city)	Date (dd-mm-yyyy)
	– –

Please return your completed application along with a copy of your void cheque 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

– visit *www.opip.ca*

– e-mail *info@opip.ca*

12 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 you also apply for insurance coverage or submit 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 contact the MIB at: Medical Information Bureau
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
416-597-0590

13 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.

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