OMA INSURANCE

Application for Resident Disability Insurance

Sun Life Financial

Policy number:
17849

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	
Alternate address (street number and name)		Apartment or suite	
City	Province	Postal code	

Have you used tobacco, tobacco cessation products, marijuana, 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 (alternate)	Telephone (cell)
Email address		

Best time and number to reach you.

Phone
- ☐ Residence
- ☐ Alternate
- ☐ 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)

3 Coverage applied for

a) Disability insurance (DI)

Minimum $500
Maximum $4,000
(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

b) DI riders – please select

- ☐ Own Occupation
- ☐ Guaranteed Insurability Benefit
- ☐ Retirement protection
- ☐ COLA

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.

Source code

For SLF use:
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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, PARI-MP or PAIRN insurance, do you currently have or have you concurrently applied for any disability income insurance?

☐ Yes If *yes*, please provide details below.

☐ No

Amount of monthly benefit	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 59997 and/or 17849

Coverage under policy 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 17849 or 59997 on approval of this application:

a) **Terminate all coverage under:** ☐ 59997 ☐ 17849

b) **Reduce coverage to:** ☐ 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 asociation/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) Location of your residency:

Hospital	City

c) Medical specialty

d) Date you began current program: Date (mm-yyyy) –

e) Date you current program is due to be completed: Date (mm-yyyy) –

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.

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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
☐ Monthly, 22nd of the month

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

If you are already insured under the OMA plan and would like to use your existing PAD arrangement, please complete the account number and transit number below for payment of premiums.	
Account number	Transit number

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 either the first or the 22nd day of each month, depending on your selection. 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.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) – Please complete and sign

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

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8 Declaration and authorization

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 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 9, 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.

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.

Signed at (city)	Signed at (province)

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

Return completed application to:

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

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OMA INSURANCE

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Keep this for your reference

9 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

10 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 or services 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 to obtain information about our privacy practices, 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.

For your records

Date and sign:

- ☐ Section 7, Request for pre-authorized debit (PAD) option
- ☐ Section 8, Declaration and authorization

Return to our office:

- ☐ Page 1 to 4
- ☐ 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.

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