Life event change form for the Physician Health Benefit Program

delivered by OMA Priority Insurance Program (OPIP)

Please PRINT clearly in ink.

In this change 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.

Clear

1 Your information

Please complete all fields.

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

2 Applying for Changes to Government Subsidized PHBP Benefits

Please complete section 3 when applying for Couple, Member plus one Dependent Child or Family coverage.

Please do not complete section 3 if applying for change to Critical Illness and/or Health Spending Account.

Must apply within 90 days of the effective date of the life-event change:

Type of life event change	Current coverage	I am applying to change my coverage to:
The loss of Critical Illness insurance under your or spouse's/partner's insurance plan on (dd-mm-yyyy)	Health Spending Account $500	☐ • Critical Illness (CI) $50, 000* • Health Spending Account $350***
The loss of Critical Illness insurance under your or spouse's/partner's insurance plan on (dd-mm-yyyy)	Health Insurance	☐ • Critical Illness (CI) $ 50, 000* • Health Insurance
The loss of Health Insurance under your or spouse's/partner's insurance plan on (dd-mm-yyyy)	Critical illness and Health Spending Account $350	☐ • Critical Illness (CI) $50, 000* • Health Insurance**
• Marriage • A dependent spouse or child becomes eligible for coverage • Birth or adoption of a child • Accepting legal guardianship of a child (dd-mm-yyyy)	Health Insurance Or Critical Illness and Health Insurance	☐ Add dependent spouse or child to existing Health Insurance coverage
I have an equivalent Extended Health Care plan and wish to opt out of the Health Insurance coverage.	Critical Illness and Health Insurance	☐ • Critical Illness (CI) $50, 000* • Health Spending Account $350***
I have an equivalent Extended Health Care plan and wish to opt out of the Health Insurance coverage.	Health Insurance	☐ Health Spending Account $500

If applying for Critical Illness please complete the following question:
Have you used tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the last 12 months? ☐ Yes ☐ No

*** 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 Health Insurance may not be eligible for PHBP Health coverage.

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

DC-101

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.

Please do not complete if applying for change to Critical Illness and/or Health Spending Account

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

5 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 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*.

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)	Date signed (dd-mm-yyyy)
X	– –
Signature of joint account holder (if both signatures required)	Date signed (dd-mm-yyyy)
X	– –

6 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) – –

7 Declaration and authorization

I declare that my answers in this form are true and complete and I understand that concealment, misrepresentation or false declaration concerning this 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 week on 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 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 and agree that this form is void unless I am an Eligible Physician as defined above.

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 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 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.

I and, if applicable, my spouse and/or dependent(s) authorize Sun Life Assurance Company of Canada and its agents and service providers to use and exchange information about me and, if applicable, my spouse and/or dependents needed for underwriting, administering and adjudicating claims under this plan and to use and exchange information with the Ontario Medical Association for the purpose of administration under this program.

My spouse/dependent(s), if applicable, authorize Sun Life Assurance Company of Canada to disclose information about them to me for the purpose of assessing this application and managing the plan.

Your signature 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
– visit *www.opip.ca*
– e-mail *info@opip.ca*

8 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 investment and 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 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 copy of our Privacy Brochure be sent to you.