Life event change form for Health and Dental insurance

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

Ref. # (if known)	Policy number
	17884

1 To be completed by plan member

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

In which provincial medical association/society are you a member for insurance eligibility?

☐ OMA ☐ DNS ☐ NBMS ☐ NLMA ☐ MSPEI

2 Life event change to existing coverage

Type of life event change

- ☐ Marriage
- ☐ Birth or adoption of a child
- ☐ Accepted legal guardianship of a child
- ☐ A dependent spouse or child has become eligible for coverage
- ☐ The loss of Health Insurance under your or your spouse's/partner's plan

Date of life event change (dd-mm-yyyy)

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

3 Benefit selection

1. Extended Health Care insurance

☐ Health **OR** ☐ Health Plus	Choose only ONE of the following options. ☐ Single ☐ Single plus one Dependent child ☐ Couple ☐ Family

2. Dental insurance

☐ Dental **OR** ☐ Dental Plus	Choose only ONE of the following options. ☐ Single ☐ Couple ☐ Family

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*)

DC-612

4 Dependent information

Complete if you checked Couple, Family or Single plus one Dependent child 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.

5 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.

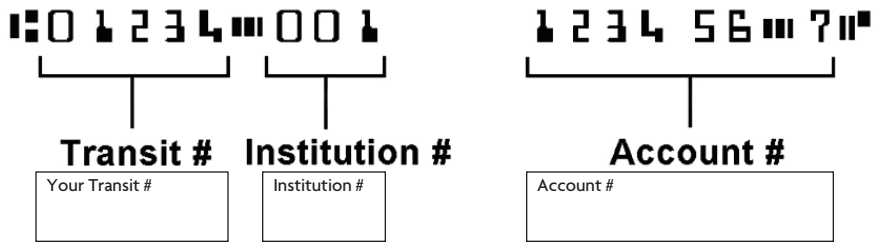
Payment options

☐ Use existing 17884 banking (no change)

☐ Change to Monthly, 1st day of the month

☐ Change to Annual, 1st of January

IF YOUR BANKING INFORMATION IS CHANGING, PLEASE ENTER THE DETAILS IN THE SPACES PROVIDED.



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.

5 Premium payments – pre-authorized debit (PAD) (continued)

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 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 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.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)

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

6 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 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.

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 return your completed application to:

OMA Insurance
PO Box 365, STN Waterloo
Waterloo, ON N2J 4A4

or fax it to:
1-800-367-0813

For more information or if you have any questions please:
call 1-800-758-1641

7 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*.