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OMA Ontario Medical Association

NEW YORK LIFE INSURANCE COMPANY

# REQUEST FOR THE ONTARIO MEDICAL ASSOCIATION GROUP TERM LIFE *PLUS 75* INSURANCE PLAN

## SECTION A: MEMBER* INFORMATION

I wish coverage for (Check One) ☐ Myself ☐ Myself and Eligible Spouse ☐ My Eligible Spouse Ref # (if known)

1. (a) Name of Member — Last name | First name | Middle Initial — (b) ☐ Male ☐ Female

   (c) Citizenship: ☐ CDN ☐ US ☐ Oth: — (d) Date of Birth: Day Month Year

2. (a) Name of Spouse (if proposed for insurance) — Last name | First name | Middle Initial — (b) ☐ Male ☐ Female

   (c) Citizenship: ☐ CDN ☐ US ☐ Oth: — (d) Date of Birth: Day Month Year

3. (a) Name of Child (if applying for insurance) — Last name | First name | Middle Initial — (b) ☐ Male ☐ Female

   (c) Date of Birth: Day Month Year

   (a) Name of Child (if applying for insurance) — Last name | First name | Middle Initial — (b) ☐ Male ☐ Female

   (c) Date of Birth: Day Month Year

   (a) Name of Child (if applying for insurance) — Last name | First name | Middle Initial — (b) ☐ Male ☐ Female

   (c) Date of Birth: Day Month Year

4. Address:

   Residence

   City | Province | Postal code | Residence Telephone ( )

   Business

   City | Province | Postal code | Business Telephone ( )

   E-mail

   **Please send correspondence to:** ☐ Residence ☐ Business

5. a) Best time/place to contact you: (choose one of each)
   PLACE ☐ Residence ☐ Business — DAY ☐ Weekdays ☐ Weekends — TIME ☐ Morning (7:00-12:00) ☐ Afternoon (12:00-5:00) ☐ Evening (5:00-8:00) ☐ Night (8:00-11:00)

   b) Best time/place to contact your spouse: (if requesting coverage)
   PLACE ☐ Residence ☐ Business — DAY ☐ Weekdays ☐ Weekends — TIME ☐ Morning (7:00-12:00) ☐ Afternoon (12:00-5:00) ☐ Evening (5:00-8:00) ☐ Night (8:00-11:00)

6. a) If you are a medical student, please indicate the date you began your undergraduate medical studies and where: Day Month Year | Province — **AND** b) Date you expect to complete your undergraduate medical studies: Month | Year

7. a) If you are a post-graduate/resident, please indicate the date you began your program and where: Day Month Year | Province — **AND** b) Date you expect to complete your program: Month | Year

   (c) Where do you intend to live/practice upon completion of your program? ☐ Canada ☐ USA ☐ Other

## SECTION A: MEMBER* INFORMATION (continued)

8. a) Date you completed post-graduate/residency in a Covered Province and where:

| Day | Month | Year | Province |
|---|---|---|---|
| | | | |

**OR** b) If you did not complete a post-graduate/residency in a Covered Province, please indicate date you began practising medicine in a Covered Province and where:

| Day | Month | Year | Province |
|---|---|---|---|
| | | | |

9. (a) Do you plan to reside outside Canada within the next 12 months? ☐ Yes ☐ No (b) If Yes, indicate Country _____ How long? _____

(c) Does your spouse (if applying for insurance) plan to reside outside Canada within the next 12 months? ☐ Yes ☐ No (d) If Yes, indicate Country _____ How long? _____

10. Is your spouse also a physician?* (if applying for insurance) ☐ Yes ☐ No ☐ I do not have a spouse If Yes, please provide name of your spouse: _____

*Please note individuals may not be insured as both a member and a spouse.
Physician/Student spouses must complete a separate application for their own life insurance coverage.

## SECTION B: TOBACCO/NICOTINE USE

11. Has any person applying for insurance ever used: tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products?

Member: ☐ Yes ☐ No

Spouse: (if proposed for insurance) ☐ Yes ☐ No

If Yes, please indicate how long used (in years) and date last used:

| Member: | How Long | Month/Year | Spouse: | How Long | Month/Year |
|---|---|---|---|---|---|
| | | | | | |

To qualify for Non-Smoker rates, you must not be using or have used any tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the past 24 months.

## SECTION C: COVERAGE REQUESTED

**Note: -Indicate the amount of coverage you wish to purchase under Policy G-29500 (excluding any coverage already in force ).**
**-Coverage applied for under this Policy and already in force under Policy G-3900-0, G-29700-0 or G-29800 (if any) combined cannot exceed $5,000,000.**

12. (a) Select an amount between $100,000 and $1,000,000 in $100,000 increments for you and/or your spouse.

**Member Plan**

(amount of coverage)
**$**

(b) Optional Coverage: Accidental Death and Dismemberment (AD&D). Select an AD&D amount between $50,000 and $500,000 in $50,000 incrementsfor you and/or your spouse.

**Member Plan**

(amount of coverage)
**$**

**Spouse Plan**

(amount of coverage)
**$**

Note: Spouse amount cannot exceed Member's amount.
Note: Principal Sum of the AD&D cannot exceed the amount of Life insurance.

(c) Do you wish to apply for the Waiver of Premium benefit on basic Member Plan insurance coverage? (If not answered, will default to NO) ☐ Yes ☐ No

**Spouse Plan**

(amount of coverage)
**$**

(d) Optional Coverage: Child Dependent Rider
Select a Child Life amount (Coverage is available in $1000 increments up to $25,000 and is not to exceed 10% of the Member or Spouse's base amount)

**Child Dependent Rider**

(amount of coverage)
**$**

Note: Applicant can only choose Child Dependent Rider on one policy.

**You will be contacted by a service provider on behalf of New York Life to ask about your medical history**

## SECTION D: FOR MEMBERS CURRENTLY INSURED UNDER GROUP POLICY G-3900-0, G-29700-0 or G-29800-0 issued by New York Life:

13. (a) ☐ I do not wish to cancel or reduce any existing coverage

(b) ☐ I request that the following coverage be terminated and/or reduced at the end of the day prior to the effective date of coverage under this plan:

**i) Coverage under Policy G-3900-0**

Member coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to $ _____ in increments of $50,000 to a minimum of $50,000

Spouse coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to $ _____ in increments of $25,000 to a minimum of $25,000

**ii) Coverage under Policy G-29700**

Member coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to $ _____ in increments of $100,000 to a minimum of $100,000

Spouse coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to $ _____ in increments of $100,000 to a minimum of $100,000

## SECTION D: FOR MEMBERS CURRENTLY INSURED UNDER GROUP POLICY G-3900-0, G-29700-0 or G-29800-0 issued by New York Life: (continued)

**iii) Coverage under Policy G-29800**

Member coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

Spouse coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

## SECTION E: OWNERSHIP INFORMATION. Required only if Owner is to be other than Member.

Applicable to life and AD&D coverage being applied for : ☐ Member ☐ Spouse ☐ Member & Spouse

| Name of owner (Last, First, Middle or Company Name)* | ☐ Male ☐ Female ☐ N/A | Date of Birth | Day Month Year |
|---|---|---|---|
| | | | |

**If Owner is a Trust, please include a copy of the Trust Document with this application form.*

| Relationship of Owner to Insured | Indicate title, if business |
|---|---|
| | |

| Mailing Address of owner | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Home Telephone | Business Telephone | E-mail |
|---|---|---|
| ( ) | ( ) | |

| Social Insurance Number (optional) (if owner is an individual) | Federal Business Number (if owner is a company) | Owner's Signature (If Business, person authorized to sign and indicate title) |
|---|---|---|
| | | |

## SECTION F: BENEFICIARY DESIGNATION Do not complete if you are designating ownership of life and AD&D insurance to a third party in Section E.

I hereby make the following life and AD&D beneficiary designations and if I am presently insured under this Group Policy (G-29500) and requesting a change in my Plan of insurance, hereby revoke any existing beneficiary designations and Optional Method of Settlement election. My spouse and I understand that the beneficiary for spouse insurance will terminate at my death in accordance with group policy provisions. If additional space is needed, please attach a separate page and sign and date.

With respect to insurance on: (only required if this is your child or sibling)

| | Beneficiary Name | Relationship | Date of Birth | Day Month Year |
|---|---|---|---|---|
| 14. (a) My Life | | | | |
| (b) My Spouse's Life (only if applying for coverage) | | | | |

## REQUEST FOR THE PRE-AUTHORIZED DEBIT (PAD) PLAN

**Your payment will be withdrawn on the 1st day of each month**

**PLEASE ENTER YOUR BANKING INFORMATION IN THE SPACES PROVIDED.**

| Your Transit # | Institution # | Account # |
|---|---|---|
| | | |

## AUTHORIZATION FOR PRE-AUTHORIZED DEBIT

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 monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account referenced above. 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 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 premium is changed or not.** You understand that the monthly premium will be due on the first 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 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, Warterloo, ON N2J 4A4 Telephone # 1-800-758-1641.

## REQUEST FOR THE PRE-AUTHORIZED DEBIT (PAD) PLAN (continued)

**Account holder(s)**

| **Signature of account holder** (if corporation, authorized person to sign and indicate title)<br>**X** | **Date signed** Day Month Year |
|---|---|
| **Signature of joint account holder** (if both signatures required)<br>**X** | **Date signed** Day Month Year |

## DECLARATION AND AUTHORIZATION

**Member Only:**

As a member of either the Ontario Medical Association, Doctors Nova Scotia, New Brunswick Medical Society, Medical Society of Prince Edward Island or Newfoundland and Labrador Medical Association, I understand and agree that this application is void unless I am in active medical practice or in medical training or retired from medical practice. I also understand that any experience refunds apportioned to the group policy will be paid to the OMA.

**Member and Spouse (if applicable):**

I request the insurance indicated on this Application. 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. I understand that New York Life may require more information and a medical exam of anyone proposed for insurance and that coverage may be invalidated if it finds that I am not eligible or such questions have not been answered truthfully and completely. I ask New York Life to rely on the information on this form and any supplements to it.

I understand that life and AD&D insurance will become effective on the date approved by New York Life if: (a) the required premium has been received by the OMA within 45 days of the date I am billed, (b) I and my approved spouse, if any, are actively performing the normal activities of a person in good health of like age on the effective date, and (c) I and my spouse (if spouse coverage is requested) are residing in Canada* on both the date this request is made and on the effective date of coverage. Any person not actively performing the normal activities of a person in good health of like age on the day insurance would otherwise become effective will not become insured until the date they are actively performing such activities provided such date is within one year of the date insurance would otherwise have been effective and they are still eligible for the insurance requested. Also, spouse coverage will not become effective if insurance on my life is not in effect under an OMA plan issued by New York Life. However, the exception will not apply if it is determined by New York Life that I (the member) am not insurable.

*Residents of Quebec are eligible if: 1) they practice or study outside of Quebec but still reside in Canada; 2) the application was signed in a province or territory other than Quebec and 3) the certificate and all other communications are delivered in a province or territory other than Quebec. I understand that the answers to Section B may result in reduced premiums and that: (a) if these answers are not true and complete this could invalidate coverage, and (b) if I or my spouse cease to be eligible for the non-smoker rates because I or my spouse use one or more of the listed products, I will be required to pay the higher smoker rates.

With respect to this application under this insurance coverage, I authorize New York Life Insurance Company, its subsidiaries, agents, Group Insurance Plan Administrator, reinsurer and service providers to use, obtain and exchange relevant information about me, for the purposes of underwriting, administration and adjudicating claims, with any person or organization including health professionals, physicians, medical practitioner, hospital, medical or medically related facility, pharmacy benefit manager, institutions, investigative agencies, MIB, Inc. or insurers about the physical and mental health of any person proposed for insurance including significant history, findings, prescription drug records and related information, diagnosis and treatment. I authorize New York Life Insurance Company to obtain from any government agencies any motor vehicle records necessary. I also authorize New York Life Insurance Company, its subsidiaries, agents, and Group Insurance Plan Administrator to use and exchange information with OMA Insurance for the purpose of administration. New York Life, its subsidiaries, agents, Group Insurance Plan Administrator may also release information to those I subsequently authorize in writing. This Authorization may be used for a period of two years from the date signed below. A photocopy of this request form shall be as valid as the original. I know that I may request a copy of this Authorization.

As the spouse of a member, I authorize New York Life Insurance Company, its subsidiaries, agents, group insurance plan administrator, reinsurer and service providers and their respective successors to disclose information in this Application, including information regarding my health, to the member for the purposes of managing and reporting on this insurance.

**Declaration by Spouse (if Spouse coverage requested):**

I hereby declare that to the best of my knowledge and belief the statements made above are true and complete. I acknowledge that I am not the certificate holder of any coverage that may be issued on my life and that I have no right to make any changes to the coverage and I have no right to designate my own beneficiary unless the member has transferred ownership of this coverage to me.

## DECLARATION AND AUTHORIZATION (continued)

| Signed at: | City | Province | Day Month Year |
|---|---|---|---|
| | | | |

| Member's Signature | Spouse's Signature (necessary only if spouse coverage is requested) |
|---|---|
| | |

| Owner's Signature (necessary only if owner is other than member) | SOURCE CODE: |
|---|---|
| | |

Underwritten by New York Life Insurance Company, Canadian Chief Agency, Toronto, Canada M5H 3C2
For purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada.

**Return original completed form to: OMA Insurance, P.O. Box 365 Stn Waterloo, Warterloo, ON N2J 4A4**

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**Please detach this page and keep for your records**

## IMPORTANT NOTICE

**How New York Life Underwrites Your Request for Group Life Insurance**

Your application for insurance may require New York Life Insurance Company to gather medical and personal information beyond what you provide in the application. This could involve a medical examination, including tests such as that for HIV (AIDS). We may also check finances, hazardous activities, driving records and drug use of the person(s) applying for insurance, and for evidence of any criminal record. If this investigation reveals positive test results for HIV or other communicable or reportable diseases, we will give the results to your doctor if you have authorized us to do so. If we do not have your written authorization, or if we are unable to provide the information to your doctor, we may disclose the test results to the appropriate public health authorities.

In considering whether the person(s) in your request for insurance qualify for coverage, New York Life will rely only on the information you furnish or for which you have provided a specific authorization, including information from MIB, Inc. and on any information we may ask you to obtain from a doctor, hospital etc. New York Life will not disclose such information to anyone unless you authorize it or where required by law. This information may be seen by New York Life, MIB, Inc. and Plan Administrator employees but only on a "need to know" basis in considering your request. We may make a brief report to MIB, Inc., however we will not disclose our underwriting decision. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

MIB, Inc. is a non-profit membership organization of life and health insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB, Inc. member company, medical or non-medical information may be given to the Bureau which on request, may then be furnished to member companies.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Please write to New York Life Insurance Company, Group Membership Association Division, 1 Rockwood Road, Sleepy Hollow, NY 10591. Although with the exception of certain jurisdictions, we cannot provide you with any medical information in our files, we will, upon written request, provide such information to a physician you designate. If you question the accuracy of the information provided by MIB, Inc., you may contact MIB, Inc. and seek a correction. The address is MIB, Inc. Information Office 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. The phone number is (416) 597-0590. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective.

**Please read carefully and keep for your records**

**Personal Checklist for Mailing**

☐ Application for OMA Insurance - Life Insurance ☐ Flex-10 ☐ Flex-20 ☐ Member ☐ Spouse ☐ Member and Spouse

☐ Member Name:

☐ Mailed on: