International Medical Graduate (IMG) Enrolment Form

OMA INSURANCE

NEW YORK LIFE

Sun Life Financial

No medical evidence required

For Group Disability Insurance Policy 17849 and/or Group Life Insurance Policy G-29500.

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

Please PRINT clearly in ink.

Ref # (if known)

Last name	First name	Middle initial	☐ Male ☐ Female
Former/Maiden name (if applicable)		Date of birth (dd-mm-yyyy)	
Residence address (street number and name)		Apartment or suite	
City	Province	Postal code	Telephone
Email address			

Have you used tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the last 24 months?
☐ Yes ☐ No

If you plan to move within the next 6 months, please indicate your new address/phone information:

Residence address (street number and name)			Effective date of change (dd-mm-yyyy)	
City	Province	Postal code	Telephone	Apartment or suite

In which provincial medical association/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.)

2 About your medical studies

Name of medical school/institute you are/were registered with for pre-residency program	
Start date (dd-mm-yyyy)	Expected graduation date (dd-mm-yyyy)
Name of medical school/university attended abroad	
Name of medical school/university matched to	
Date you expect to begin your residency (dd-mm-yyyy)	

DC-101

Source code

3 Life insurance

Waiver of Premium feature does not apply.

☐ Yes – I am applying for $100,000 of complimentary life insurance*

In the event of your death, the proceeds of this insurance will be paid to your estate, unless there is a signed beneficiary designation in our file. At the time of certificate issue and delivery, you will have the opportunity to appoint a named beneficiary by providing us with a duly completed and signed Beneficiary form that will be included in your welcome package.

* Note. If you are already insured under policy G-29500 or you are insured as a spouse under G-3900, G-29500 or G-29700, you are not eligible for this offer.

4 Disability insurance

I am applying for:

a) ☐ $4,000 Disability Monthly Benefit

b) ☐ Cost of Living Adjustment rider

c) I would like my premium rate to be:

☐ Step or
☐ Level

Note: If you do NOT check a box, we will consider the premium rate as Step.

5 Insurance information

Note: **Do not cancel any existing coverage until the coverage you have applied for has been approved.**

Other than OMA insurance, do you currently have or have you concurrently applied for any disability income insurance?

☐ Yes ☐ No

If *yes*, please provide amount and details below

Amount of monthly benefit	Insuring company	Date of issue (mm-yyyy)	Indicate if any coverage will be discontinued if this coverage is approved.
$		–	☐ Yes ☐ No If *yes*, amount. $
$		–	☐ Yes ☐ No If *yes*, amount. $

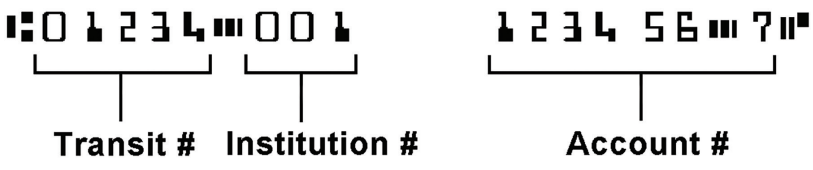
6 Request for pre-authorized debit (PAD) option

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

PLEASE ENTER YOUR BANKING INFORMATION 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:

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 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	– –

7 Declaration and authorization

* Residents of Quebec are eligible if 1) they study outside of Quebec but still reside in Canada; 2) the Enrolment form is signed in a province or territory other than Quebec; and 3) the certificate and all other communications will be delivered in a province or territory other than Quebec.

I declare that my answers in this Enrolment form are true and complete and I understand that concealment, misrepresentation or false declaration concerning this Enrolment form will cause this insurance to be void. I understand and agree that this Enrolment Form is void unless: (a) I am a member of the Ontario Medical Association, Doctors Nova Scotia, New Brunswick Medical Society, Medical Society of Prince Edward Island, or Newfoundland and Labrador Medical Association, (b) I am enrolled full-time in medical school, and (c) I reside in Canada* on the date of this application.

I understand that this request for coverage will be accepted up to 60 days prior to the commencement of medical school, and that insurance will become effective on the later of the date this request for coverage is received by OMA Insurance or the date I begin medical school, provided I am alive and any premium contribution required has been received by OMA Insurance within 45 days of the date I am billed.

I understand that I am applying for Disability Income insurance under Policy 17849 issued by Sun Life Assurance Company of Canada and/or Life insurance under Policy G-29500 issued by New York Life Insurance Company. Regarding the life insurance policy, for the 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.

With respect to this Enrolment form, I authorize Sun Life Assurance Company of Canada and New York Life Insurance Company and their agents and service providers to collect, use and disclose relevant information about me for the purposes of underwriting, administration and adjuticating claims with any person or organization who has relevant information about me including institutions, 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 shall be as valid as the original.

Please ensure you sign your application.

Signed at (city)	Signed at (province)

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

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 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.

Return completed application to:

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