OMA Ontario Medical Association

Sun Life

Application to Exercise Guaranteed Disability Insurability Benefit Option

Coverage to be issued under Ontario Medical Association Group Disability Policy 59997

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 group of companies.

Ref. number as shown on your letter

Clear

1 General information

Please PRINT clearly in ink.

Send correspondence to:
☐ Residence address
☐ Business address

Last name	First name	Middle initial	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)

Residence address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone (residence)

Business address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone (business)

Telephone (cell)	E-mail address

In which provincial medical association/society are you a member for insurance eligibility?
☐ OMA ☐ DNS ☐ NBMS ☐ NLMA ☐ MSPEI

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

2 Coverage information

Residents can apply to exercise the 2023 option if they currently have less than $3,500 monthly benefit in force with the OMA or less than $4,000 from all sources (excluding PARO, PARNL or Maritime Resident Doctors coverage).

1. Amount of additional monthly benefit applied for: (in $100 units)*:
   *up to $2,500 available if age 45 and under
   *up to $1,500 available if age 46 to 55

   $

2. Elimination period desired**:
   ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days
   **For the GIB option, the Elimination Period (EP) cannot be shorter than the EP you already have in force.

3 For residents only

1. a)

Location of your post graduate program: hospital (city)	Province

Type of program (specialty)

b) Date you began current program: dd-mm-yyyy

c) Date your current program is due to be completed: dd-mm-yyyy

DC-124

Advisor name

Source code 08-411

4 Practice information

1. a) Medical specialty:

   Date first commenced practice in specialty (if within the last two years): dd-mm-yyyy

   b) Are you currently working at least 25 hours per week? ☐ Yes ☐ No

If you are on leave of absence or parental leave, you may exercise one option amount up to $1,000 which will become effective when you return to work for a minimum of 15 hours a week for a continuous period of 30 days.

   c) If you are currently on a parental leave of absence, what is your expected return to work date? dd-mm-yyyy

   d) Average number of hours worked per week: If less than 25 hours, please explain:

   e) Average number of weeks worked per year: If less than 46, please explain:

Any amount approved during a period of disability will apply only to any new disability.

2. Are you now disabled from performing the duties of your occupation and/or on claim and/or satisfying an elimination period? ☐ Yes ☐ No

   If "Yes", please indicate the date you became disabled: Date (dd-mm-yyyy)

5 Information on any other disability insurance

1. Do you currently have disability insurance in force or have you concurrently applied for any disability income coverage, including with your employer (other than OMA Insurance)? ☐ Yes ☐ No

   If "Yes", please provide details below:

Amount of monthly benefit	Insuring company	Indicate if individual or group/association	Date of issue (dd-mm-yyyy)	Taxable benefits
$				☐ Yes ☐ No
$				☐ Yes ☐ No

2. If "Yes" to 1, will any disability coverage be discontinued if this application is approved? ☐ Yes ☐ No

   If "Yes", please indicate the Insuring Company and Amount below:

Insuring company	Amount
	$

6 Financial information

Physicians in their first two years of practice applying for coverage amounts of up to $7,000 for General Practitioners and $10,000 for Specialists do not need to complete this section.

a) Please indicate your business structure:

☐ Sole owner ☐ Partnership ☐ Corporation State your % of ownership %

☐ Associate ☐ Employee

b) If any portion of your income is from a salaried position, please provide your salary:

$

c) Net annual earned income (gross income less business expenses)

Current year-to-date	Actual previous year
$	$

d) Please indicate any unearned income in excess of $10,000 per annum (investment income not dependent on ability to work, not including RRSP's)

Amount of unearned income	Source (securities, bonds, real estate, etc.)
$	

6 Financial information (continued)

e) Have you ever declared, or are you contemplating bankruptcy?
☐ Yes ☐ No If "Yes", please indicate date of discharge.

Date (mm-yyyy)
–

f) Do you have any income which will continue under a partnership arrangement or employment contract, should you become disabled?
☐ Yes ☐ No If "Yes", please provide the amount and details in the space provided below.

Amount	Details
$	

7 Financial documentation

The following documentation will be required depending on your financial reporting situation.

If applying for DI insurance, financial documentation is required to confirm your income unless you commenced practice within the last two years in Canada.

DI insurance

Employee (Salaried)	Sole Proprietor or Partnership	Incorporated
• Most current T4 or • Income Tax Return (Pages 1 to 4)	• Income Tax Return (Pages 1 to 4) or • Statement of Business or Professional Activities (T2125)	• Most current T4 or • Personal Income Tax Return (Pages 1 to 4) and • Business Financial Statements of the Corporation

☐ I am enclosing the required documentation, or
☐ Please contact my accountant to obtain the required income documentation:

Accountant's name	
Address	
Telephone number – –	Fax number – –
Email	

8 Declaration and authorization

I declare that my answers in this Application are true and complete and I understand that concealment, misrepresentation and 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, I understand and agree that (a) if issued, the Option Amount will become effective on the date the application is received by OMA Insurance, but not earlier than May 1st, 2023, provided the application is received no later than May 31st, 2023; (b) the new Certificate will have the same exclusion(s) as specifically excluded from the Guaranteed Insurability Benefit Option rider under the Certificate and (c) the new Certificate shall be subject to the terms of the Rider under which this option is being exercised. I authorize Sun Life Assurance Company of Canada, the OMA as plan administrator and their agents, and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this insurance coverage.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage.

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

Forward your completed application to:

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

9 Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.