OMA Insurance

Enrolment form for the Physician Health Benefit Program (PHBP)

delivered by OMA Priority Insurance Program (OPIP)

Sun Life

Please PRINT clearly in ink.

In this enrolment 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 is the insurer, and is a member of the Sun Life group of companies.**

Clear

1 Your information

Please complete all fields.

First name	Middle initial	Last name

Ref # (if known)

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	Fax	Email address
_ _ _	_ _ _	

If you are age 65 and under, please indicate whether you are a non-smoker or smoker.

Have you used tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the last 12 months?
☐ Yes ☐ No

Practice information

Date first commenced practice in specialty/fellowship in Canada (dd-mm-yyyy)	Date residency/fellowship completed (dd-mm-yyyy)
_ _ _ _	_ _ _ _

Following the completion of your residency/fellowship, will you be pursuing further residency/fellowship training? ☐ Yes ☐ No

2 Government subsidized PHBP benefits selection

Under age 65

• Critical Illness insurance $50,000* • Health insurance ☐ Single ☐ Couple ☐ Member plus one Dependent child ☐ Family	**OR**	☐ Critical Illness insurance $50,000 Health Spending Account $350** The Health Spending Account is only available to members who have an equivalent extended health care plan and wish to opt out of Health coverage.

Age 65 and over

• Health insurance ☐ Single ☐ Couple ☐ Member plus one Dependent child ☐ Family	**OR**	☐ Health Spending Account $500** The Health Spending Account is only available to members who have an equivalent extended health care plan and wish to opt out of Health coverage.

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

DC-101

Advisor name

Source code WEB

3 Additional self-funded options

Monthly or Annual Premium are applicable/to be paid by member for self-funded options applied for.

Note: Medical Evidence is not required for Health Plus if applied within time limit of OPIP Newly Eligible Offer.

PHBP Coverage selected in section 2	Additional coverage you can select
Critical Illness and Health	☐ Health Plus
	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family **or** ☐ Dental*** ☐ Single ☐ Couple ☐ Family
	☐ Member Critical Illness insurance $50,000 without medical evidence – Policy 017862 (in addition to the $50,000 under OPIP)****
	☐ Spouse Critical Illness insurance $50,000 without medical evidence – Policy 017862
Critical Illness and Health Spending Account $350	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family **or** ☐ Dental*** ☐ Single ☐ Couple ☐ Family
	☐ Member Critical Illness insurance $50,000 without medical evidence – Policy 017862 (in addition to the $50,000 under OPIP)****
	☐ Spouse Critical Illness insurance $50,000 without medical evidence – Policy 017862
Health	☐ Health Plus
	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family **or** ☐ Dental*** ☐ Single ☐ Couple ☐ Family
Health Spending Account $500	☐ Dental Plus*** ☐ Single ☐ Couple ☐ Family **or** ☐ Dental*** ☐ Single ☐ Couple ☐ Family

***Dental/Dental Plus – Policy 017884 No medical evidence required
Available to members under age 79

**** The combined critical illness coverage under the OMA Priority Insurance Program or SunCI Plus plan or the OMA Group Critical Illness Plan cannot exceed $300,000. If your spouse is also a physician, you may not apply for more than the total amount of $300,000 as a physician or spouse.

4 Dependent details

Complete if you checked Couple, Member plus one dependent or Family 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
			_ _	

Have you used tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the last 12 months?
☐ No ☐ Yes

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 For Members currently insured under Group Health Policy #17884

Indicate below only if you wish to terminate coverage under Group Health Policy 17884

a) ☐ Yes

b) ☐ No

6 Payment information

Health Plus and Critical Illness premiums to be paid monthly 1st day of each month. Annual payment is not available for these benefits.

Acknowledgment of OPIP contributions and premiums

I understand that the OPIP annual contribution and/or premium is due on January 1st of each year and any monthly premium is due on the 1st day of each month.

Payment selection for self-funded option

Select payment schedule if applying for additional self-funded options.

☐ Annually, 1st of January (Dental and Critical Illness only)

☐ Monthly, 1st day of the month

PLEASE ENTER YOUR BANKING INFORMATION IN THE SPACES PROVIDED.

Your Transit #	Institution #	Account #

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payor(s) name (first and last) or full legal name of corporation/entity			
If applicable, date of birth (dd-mm-yyyy) _ _	Relationship		
Address (street number and name)			Apartment or suite
City	Province	Country	Postal code

6 Payment information (continued)

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 contributions and premiums under this benefits program through a Pre-Authorized Debit (PAD) from the account referenced in my application. 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 contributions and premiums 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 contributions and premiums is changed or not.** Depending on the product selected by you, premiums are withdrawn on an annual and/or monthly basis. You understand that the annual contribution and/or premium is due on January 1st of each year and any monthly premium is due on the 1st day of each month. 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 in my application. 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. Y**ou 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 the annual contribution and/or premium is due on January 1st of each year and any monthly premium is due on the 1st day of each month. 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 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.payments.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.payments.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)

Print account holder last name	Print account holder first name	Signature of account holder (if business, authorized person to sign and indicate title) X	Date signed (dd-mm-yyyy) _ _ _ _
Print joint account holder last name	Print joint account holder first name	Signature of joint account holder (if both signatures required) X	Date signed (dd-mm-yyyy) _ _ _ _

7 Application for subsidy

Please **ensure only one** subsidy option is selected.

1. ☐ **I am applying for the MOHLTC 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) – –

OR

If your professional corporation is applying for the MOHLTC subsidy, please provide your Corporation name.

2. ☐ **My professional corporation is applying for the MOHLTC 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 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	Title of signing officer
Location signed (city)	Date (dd-mm-yyyy) – –

8 Declaration and authorization

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 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:

*Residents of Quebec are eligible if 1) they work in Ontario: 2) the Enrolment 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.

1. **resides in Canada*;**
2. **is registered with the College of Physicians and Surgeons of Ontario; and has acquired an independent practice license;**
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*.**

I declare I am enrolling within 90 days of receiving my enrolment package or the date I have: completed residency/fellowship; or begun practising in Ontario; or returned to work from a parental leave of absence or disability. I understand and agree that this enrolment 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, except during a period of disability, or if I am on a parental leave of absence for more than eighteen months. 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.

Your signature X	
Location signed (city)	Date (dd-mm-yyyy) _ _ _ _

Please ensure you sign your completed application before sending 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 1-866-527-9260 or 416-408-8420
– visit *www.opip.ca*
– email *info@opip.ca*

9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life 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*.