OMA Insurance

Medical Student Enrolment Form

NEW YORK LIFE

Sun Life

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 group of companies.

Ref # (if known)

Please PRINT clearly in ink.

1 Member information

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, 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)				Apartment or suite
City	Province	Postal code	Telephone	Effective date of change (dd-mm-yyyy)

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

a) What was your start date of medical school? dd-mm-yyyy

b) When do you expect to graduate? dd-mm-yyyy

c) Which medical school do you attend?

d) What is your current year of medical school: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

e) If you are in a program with an extended period of study, provide the reason(s)

DC-123

Advisor name

Source code WEB

3 Life insurance

☐ Yes – I am applying for $100,000 of complimentary life insurance* (Waiver of Premium feature does not apply.)

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.

It is important to note that premium payment withdrawals for your Student complimentary Life Insurance will begin on September 1st in the year that you transition into residency. No Life Insurance premiums will be withdrawn from the bank account on file until that time.

* 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) ☐ First/Second Year: $1,500 Disability Monthly Benefit
   ☐ Third Year: $2,500 Disability Monthly Benefit (Second Year for McMaster students)
   ☐ Fourth Year: $4,000 Disability Monthly Benefit (Third Year for McMaster students)

b) ☐ Yes I am applying for the Cost of Living Adjustment rider

c) I would like my premium rate to be:
   ☐ Step
   ☐ 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.
$			

6 Disability insurance questionnaire – complete if applying for disability insurance

1. Are you currently enrolled full-time in a medical school and able to perform all the essential duties of your medical school program?
   ☐ Yes ☐ No
2. In the last 5 years, have you been treated for, had symptoms of, or consulted a doctor or other healthcare professional for anxiety, depression, burnout, schizophrenia, psychosis or any other psychological disorder? ☐ Yes ☐ No
3. In the last 12 months, have you been treated for, had symptoms of, or consulted a doctor or other healthcare professional for any disease, disorder or injury (including sprains & strains) of the bones, joints, tendons, muscles or limbs including knees, hips, shoulders, back or neck that lasted more than one week or recurred more than once in the same location? ☐ Yes ☐ No
   If Yes, indicate affected joint(s):
4. In the last 12 months, have you applied for insurance where the insurance company didn't approve the application or issued the insurance with some changes? ☐ Yes ☐ No

7 Premium payment method

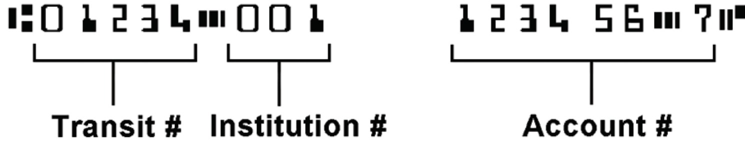
Payment options

a) Pre-authorized debit (PAD) option.

- ☐ Annually, 1st of September
- ☐ Monthly, 1st day of the month

There are no additional charges for paying on a monthly basis – the annual premium is simply divided by 12 months.

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 to you		
Address (street number and name)			Apartment or suite
City	Province	Country	Postal code

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*

7 Premium payment method (continued)

Account holder(s) – Please complete and sign

Print account holder name (full name or corporation/entity 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)

b) Credit card option (charge my premium to my Visa and/or MasterCard)

Payment frequency

☐ Monthly ☐ Annually

Once we have approved your application, you will be contacted by a Sun Life call centre representative to obtain your credit card information.

Terms and conditions

In connection with your required premium under this benefit plan, you authorize us to: charge your credit card for the insurance premium owing, cancel this authorization 10 days after you have provided written notice to us, and to automatically cancel this agreement if we are unable to charge your credit card.

Send no money with this application. You will be notified with a premium statement.

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 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 enroled 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.

I authorize Sun Life Assurance Company of Canada, New York Life Insurance Company, and their agents and service providers to collect, use and disclose information about me for the purposes of underwriting, administration and adjudicating claims to each other and to any person or organization who has relevant information about me, including institutions, investigative agencies, insurers, and reinsurers.

I further authorize Sun Life Assurance Company of Canada, New York Life Insurance Company, and OMA Insurance and their agents and service providers to collect, use and exchange information about me for the purpose of Plan 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)	Province
Signature of applicant X	Date signed (dd-mm-yyyy)

* 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.

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*.

Return completed application to:

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