

Essentials for Residents Application

Ref # (if known)

Policy number
140004
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.

Please PRINT clearly.

1 Member information

Last name		First name		Middle initial
Former/Maiden name (if applicable)			Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Residence address (street number and name)				Apartment or suite
City	Province	Postal code	Telephone (Residence)	
Email address				
Alternate address (street number and name)				Apartment or suite
City		Province	Postal code	
Have you used tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

2 Coverage applied for

a) **Disability Insurance (DI) on a 90 day Elimination Period**

Amount of insurance applied for in increments of \$100
 \$

Minimum \$500
 Maximum \$4,500 (from all sources)

b) **DI riders – please select**

- Own Occupation \$500 Retirement Protection
 Guaranteed Insurability Benefit COLA

Note: If you do NOT check a box, we will not consider the above rider(s) if it is not already in force.

c) **Indicate the type of DI premium rate** Step Level

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

Advisor name



2 Coverage applied for (continued)

d) Yes – I am applying for \$200,000 of 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 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 No Life Insurance premiums will be withdrawn from the bank account on file until that time.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.

3 Insurance information

Note: Do not cancel any existing coverage until the coverage you have applied for has been approved.
 Other than any OMA insurance provided by Sun Life or, PARO, PARNL and Maritime Resident Doctors 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)	Are benefits taxable?	Indicate if any coverage will be discontinued if this coverage is approved
\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please amount \$
\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please amount \$

4 Occupational information

a) 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.)

b) Location of your residency:

Hospital

City

c) Medical specialty:

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d) Date first you began program:

Date (mm-yyyy)

e) Date your current program is due to be completed:

Date (mm-yyyy)

f) Average number of hours worked per week:

	If less than 25 hours, please explain.
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g) Average number of weeks worked per year:

	If less than 46 weeks, please explain.
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5 Medical questionnaire for Disability Insurance

1. In the last 5 years, have you been treated for, had symptoms of, or consulted a doctor or other healthcare professional for anxiety, depression, schizophrenia, psychosis, or any other psychological disorder? Yes No

2. 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 and 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, please provide location of affected bone, joint, tendon, muscle or limb:

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3. In the last 12 months, have you applied for insurance where the insurance company did not approve the application or issued the insurance with some changes? Yes No
 If yes, please state reason for the changes:

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6 Premium payment method – select PAD or Credit Card

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

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 #
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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 1st each year. If you selected to pay your premium monthly, it will be due on the first day 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

Waterloo, ON N2J 4A4

Telephone # 1-800-758-1641

Email: Can_AssocAndAffinity@sunlife.com

6 Premium payment method – select PAD or Credit Card (continued)**Account holder(s) – Please complete and sign**

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)	

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.

7 Declaration and authorization

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. As 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 this application is void unless I am in active medical training in Canada and reside in Canada on both the date of this application and on the effective date of coverage.

I understand that I am applying for Disability Income insurance under Policy 140004 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.

I understand that if the application for insurance is approved by the Company other than applied for with special exclusions, the special exclusions apply to:

- any automatic increase in insurance coverage issued under the policy and accepted by the Insured Member, and
- Option Amount obtained under the Guaranteed Insurability Benefit Rider.

A photocopy or electronic version of this authorization is as valid as the original.

Please ensure you sign your application.

Signed at (city)		Signed at (province)	
Signature of applicant X		Date signed (dd-mm-yyyy)	

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

8 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.