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OMA Ontario Medical Association

NEW YORK LIFE INSURANCE COMPANY

REQUEST FOR THE ONTARIO MEDICAL ASSOCIATION GROUP FLEX-TERM LIFE INSURANCE PLAN

I wish to apply for: ☐ Flex-10 Policy G-29700 ☐ Flex-20 Policy G-29800

SECTION A: MEMBER* INFORMATION

*A member includes an individual who becomes a member of an eligible association/society within 30 days of the date of this application

I wish coverage for (Check One) ☐ Myself ☐ Myself and Eligible Spouse ☐ My Eligible Spouse Ref # (if known)

1. Member: (a) Name | Last name | First name | Middle Initial | (b) ☐ Male ☐ Female

(c) Citizenship: ☐ Canadian ☐ Other ☐ USA (d) Date of Birth | Day | Month | Year

2. Spouse: (a) Name (if applying for insurance) | Last name | First name | Middle Initial | (b) ☐ Male ☐ Female

(c) Citizenship: ☐ Canadian ☐ Other ☐ USA (d) Date of Birth | Day | Month | Year

3. Child 1: (a) Name (if applying for insurance) | Last name | First name | Middle Initial | (b) ☐ Male ☐ Female

(c) Date of Birth | Day | Month | Year

Child 2: (a) Name (if applying for insurance) | Last name | First name | Middle Initial | (b) ☐ Male ☐ Female

(c) Date of Birth | Day | Month | Year

Child 3: (a) Name (if applying for insurance) | Last name | First name | Middle Initial | (b) ☐ Male ☐ Female

(c) Date of Birth | Day | Month | Year

4. Address:

Residence		Residence Telephone ( )	
City	Province	Postal code	E-mail

Business		Business Telephone ( )	
City	Province	Postal code	**Please send correspondence to:** ☐ Residence ☐ Business

Spouse E-mail (if applicable)	Spouse Residence Telephone ( )	Spouse Business Telephone ( )

In order to complete your application, you will be contacted by a service provider on behalf of New York Life to ask about your medical history

5. a) Best time/place to contact you: (choose one of each) PLACE ☐ Residence ☐ Business DAY ☐ Weekdays ☐ Weekends TIME ☐ Morning (7:00-12:00) ☐ Afternoon (12:00-5:00) ☐ Evening (5:00-8:00) ☐ Night (8:00-11:00)

b) Best time/place to contact your spouse: (if requesting coverage) PLACE ☐ Residence ☐ Business DAY ☐ Weekdays ☐ Weekends TIME ☐ Morning (7:00-12:00) ☐ Afternoon (12:00-5:00) ☐ Evening (5:00-8:00) ☐ Night (8:00-11:00)

6. a) If you are a medical student, please indicate the date you began your undergraduate medical studies and where: | Day | Month | Year | Province | **AND** b) Date you expect to complete your undergraduate medical studies: | Month | Year |

(c) Where do you intend to live/practice upon completion of your program? ☐ Canada ☐ USA ☐ Other

SECTION A: MEMBER* INFORMATION (continued)

7. a) If you are a post-graduate/resident, please indicate the date you began your program and where:

Day	Month	Year	Province

AND b) Date you expect to complete your program:

Month	Year

(c) Where do you intend to live/practice upon completion of your program? ☐ Canada ☐ USA ☐ Other

8. a) Date you completed post-graduate/residency in a Covered Province and where:

Day	Month	Year	Province

OR b) If you did not complete a post-graduate/residency in a Covered Province, please indicate date you began practising medicine in a Covered Province and where:

Day	Month	Year	Province

9. (a) Do you plan to reside outside Canada within the next 12 months? ☐ Yes ☐ No (b) If Yes, indicate Country _____ How long? _____

(c) Does your spouse (if applying for insurance) plan to reside outside Canada within the next 12 months? ☐ Yes ☐ No (d) If Yes, indicate Country _____ How long? _____

10. Is your spouse also a physician?* (if applying for insurance) ☐ Yes ☐ No ☐ I do not have a spouse (b) If Yes, please provide name of your spouse: _____

*Please note individuals may not be insured as both a member and a spouse.
Physician/Student spouses must complete a separate application for their own life insurance coverage.

SECTION B: TOBACCO/NICOTINE USE

11. Has any person applying for insurance ever used: tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products?

Member: ☐ Yes ☐ No Spouse: (if proposed for insurance) ☐ Yes ☐ No

If Yes, please indicate how long used (in years) and date last used:

Member: How Long	Month/Year	Spouse: How Long	Month/Year

To qualify for Non-Smoker rates, you must not be using or have used any tobacco, tobacco cessation products, marijuana, nicotine in any form or nicotine replacement products in the past 24 months.

SECTION C: COVERAGE REQUESTED

Note: -Refer to website for eligibility, options and coverage description.
-Indicate the amount of coverage you wish to purchase under Policy G-29700 (Flex 10) and/or G-29800 (Flex 20) excluding any coverage already in force under these policies.
-Coverage applied for on this application and already in force under Policy G-3900-0 or G-29500 or G-29700 or G-29800 (if any) combined cannot exceed $5,000,000.

Flex-10

12. (a) Select an amount between $100,000 and $3,000,000 in $25,000 increments for you and/or your spouse.

Member Plan	Spouse Plan
(amount of coverage) $	(amount of coverage) $

(c) Do you wish to apply for the Waiver of Premium benefit on basic Member Plan insurance coverage? (If not answered, will default to NO) ☐ Yes ☐ No

(d) Optional Coverage: Child Dependent Rider
Select a Child Life amount (Coverage is available in $1000 increments up to $25,000 and is not to exceed 10% of the Member or Spouse's base amount)

Child Dependent Rider
(amount of coverage) $

Note: Applicant can only choose Child Dependent Rider on one policy.

(b) Optional Coverage: Accidental Death and Dismemberment (AD&D). Select an AD&D amount between $50,000 and $500,000 in $50,000 incrementsfor you and/or your spouse.

Member Plan	Spouse Plan
(amount of coverage) $	(amount of coverage) $

Note: Spouse amount cannot exceed Member's amount.
Note: Principal Sum of the AD&D cannot exceed the amount of Life insurance.

SECTION C: COVERAGE REQUESTED (continued)

Flex-20

13. (a) Select an amount between $100,000 and $3,000,000 in $25,000 increments for you and/or your spouse.

Member Plan	Spouse Plan
(amount of coverage) **$**	(amount of coverage) **$**

(c) Do you wish to apply for the Waiver of Premium benefit on basic Member Plan insurance coverage? (If not answered, will default to NO) ☐ Yes ☐ No

(d) Optional Coverage: Child Dependent Rider
Select a Child Life amount (Coverage is available in $1000 increments up to $25,000 and is not to exceed 10% of the Member or Spouse's base amount)

Child Dependent Rider

(amount of coverage) **$**

Note: Applicant can only choose Child Dependent Rider on one policy.

(b) Optional Coverage: Accidental Death and Dismemberment (AD&D). Select an AD&D amount between $50,000 and $500,000 in $50,000 incrementsfor you and/or your spouse.

Member Plan	Spouse Plan
(amount of coverage) **$**	(amount of coverage) **$**

Note: Spouse amount cannot exceed Member's amount.
Note: Principal Sum of the AD&D cannot exceed the amount of Life insurance.

SECTION D: INTERIM INSURANCE

Insurance equal to the lesser of the amount of life insurance requested and $1,000,000 is available provided you (and your spouse, if requesting interim insurance) meet the following four conditions:

- **Request interim insurance in item 1 below**
- **Are able to answer" No" to the health questions below**
- **Submit with this request your pre-authorized debit payment information**
- **Have no other New York Life Interim Insurance in force at the time of your request**

Complete terms and conditions of the Interim Insurance are in the Interim Insurance Agreement attached to this Request for Insurance.

I wish to apply for Interim Insurance on: ☐ Flex-10 ☐ Flex-20

	Member		Spouse	
1. I request Interim Life Insurance on:	☐ Yes	☐ No	☐ Yes	☐ No

2. Health Statement: To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse if applicable.

If an applicant answers Yes to any of the 4 questions below, chooses not to answer them, or is not an eligible member or an eligible spouse, then that person is not eligible for Interim Insurance.

Have you or your spouse (if applying for Interim Insurance):

	Member		Spouse	
a) Within the past 90 days, have you consulted or been treated by a healthcare provider (for anything other than an uncomplicated pregnancy or any minor condition for which no follow-up visit has been arranged or contemplated)?	☐ Yes	☐ No	☐ Yes	☐ No
b) Within the last 2 years, been unable to work or unable to attend school, or been disabled for one month or more?	☐ Yes	☐ No	☐ Yes	☐ No
c) Within the last 2 years, other than normal childbirth, been admitted to a hospital or other medical facility for more than 5 consecutive days?	☐ Yes	☐ No	☐ Yes	☐ No
d) Within the last 12 months, had any application for life insurance, change or reinstatement declined, rated or modified in any way?	☐ Yes	☐ No	☐ Yes	☐ No

NOTE: Interim Insurance does NOT apply to Accidental Death & Dismemberment Coverage.
In order for your requested Interim Insurance to be accepted, you must:
- fully complete this entire application
- provide pre-authorized debit information, and
- submit within 30 days of the date of the application.

SECTION E: FOR MEMBERS CURRENTLY INSURED UNDER GROUP POLICY G-3900-0, G-29500, G-29700 or G-29800 issued by New York Life:

14. (a) ☐ I do not wish to cancel or reduce any existing coverage

(b) ☐ I request that the following coverage be terminated and/or reduced at the end of the day prior to the effective date of coverage under this plan:

i) Coverage under Policy G-3900-0

Member coverage:	☐ Terminate all coverage	**OR**	☐ Reduce coverage to	**$**	in increments of $50,000 to a minimum of $50,000
Spouse coverage:	☐ Terminate all coverage	**OR**	☐ Reduce coverage to	**$**	in increments of $25,000 to a minimum of $25,000

i) Coverage under Policy G-29500

Member coverage:	☐ Terminate all coverage	**OR**	☐ Reduce coverage to	**$**	in increments of $100,000 to a minimum of $100,000
Spouse coverage:	☐ Terminate all coverage	**OR**	☐ Reduce coverage to	**$**	in increments of $100,000 to a minimum of $100,000

continued on next page

SECTION E: FOR MEMBERS CURRENTLY INSURED UNDER GROUP POLICY G-3900-0, G-29500, G-29700 or G-29800 issued by New York Life: (continued)

i) Coverage under Policy G-29700

Member coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

Spouse coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

i) Coverage under Policy G-29800

Member coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

Spouse coverage: ☐ Terminate all coverage **OR** ☐ Reduce coverage to **$** _____ in increments of $100,000 to a minimum of $100,000

SECTION F: OWNERSHIP INFORMATION. Required only if Owner is to be other than Member.

If additional space is needed, please attach a separate page and sign and date.

15. Applicable to life and AD&D coverage being applied for : ☐ Member ☐ Spouse ☐ Member & Spouse

☐ Flex-10 ☐ Flex-20

Name of owner (Last, First, Middle or Company Name)*

☐ Male ☐ Female ☐ N/A

Date of Birth Day Month Year

**If Owner is a Trust, please include a copy of the Trust Document with this application form.*

Relationship of Owner to Insured

Mailing Address of owner	City	Province	Postal code

Business Telephone ( )	E-mail

If owner is an individual: Social Insurance Number (optional)	If owner is a company: Federal Business Number	If owner is a business, name and title of person authorized to sign:

SECTION G: BENEFICIARY DESIGNATION Do not complete if you are designating ownership of life and AD&D insurance to a third party in Section F.

I hereby make the following life and AD&D beneficiary designations to any Certificate of Insurance resulting from this application. My spouse and I understand that the beneficiary for spouse insurance will terminate at my death in accordance with group policy provisions. If a beneficiary is not designated, benefits will be paid to the executor or administrator of the owner's estate in accordance with the Group Policy provisions If additional space is needed, please attach a separate page and sign and date.

With respect to insurance for ☐ Flex-10 ☐ Flex-20

(only required if this is your child or sibling)

	Beneficiary Name	Relationship	Date of Birth Day Month Year
16. (a) My Life			
(b) My Spouse's Life (only if applying for coverage)			

REQUEST FOR THE PRE-AUTHORIZED DEBIT (PAD) PLAN

Your payment will be withdrawn on the 1st day of each month

PLEASE ENTER YOUR BANKING INFORMATION IN THE SPACES PROVIDED.

Your Transit #	Institution #	Account #

AUTHORIZATION FOR PRE-AUTHORIZED DEBIT

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 monthly premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account referenced above. 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 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 premium is changed or not.** You understand that the monthly premium will be due on the first 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.

AUTHORIZATION FOR PRE-AUTHORIZED DEBIT (continued)

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, Warterloo, ON N2J 4A4 Telephone # 1-800-758-1641.

Account holder(s)

Signature of account holder (if corporation, authorized person to sign and indicate title) **X**	**Date signed** Day Month Year

Signature of joint account holder (if both signatures required) **X**	**Date signed** Day Month Year

DECLARATION AND AUTHORIZATION (for application)

Member Only:

As a member of either the Ontario Medical Association, Doctors Nova Scotia, New Brunswick Medical Society, Medical Society of Prince Edward Island or Newfoundland and Labrador Medical Association, I understand and agree that this application is void unless I am in active medical practice or in medical training or retired from medical practice. I also understand that any experience refunds apportioned to the group policy will be paid to the OMA.

Declaration by Spouse (if Spouse coverage requested):

I hereby declare that to the best of my knowledge and belief the statements made above are true and complete. I acknowledge that I am not the certificate holder of any coverage that may be issued on my life and that I have no right to make any changes to the coverage and I have no right to designate my own beneficiary unless the member has transferred ownership of this coverage to me.

Member and Spouse (if applicable):

I request the insurance indicated on this Application. 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. I understand that New York Life may require more information and a medical exam of anyone proposed for insurance and that coverage may be invalidated if it finds that I am not eligible or such questions have not been answered truthfully and completely. I ask New York Life to rely on the information on this form and any supplements to it.

I understand that life and AD& D insurance will become effective on the date approved by New York Life if: (a) the required premium has been received by the OMA within 45 days of the date I am billed, (b) I and my approved spouse, if any, are actively performing the normal activities of a person in good health of like age on the effective date, (c) I am a member of an eligible association/society on that date and (d) I and my spouse (if spouse coverage is requested) are residing in Canada* on both the date this request is made and on the effective date of coverage. Any person not actively performing the normal activities of a person in good health of like age on the day insurance would otherwise become effective will not become insured until the date they are actively performing such activities provided such date is within one year of the date insurance would otherwise have been effective and they are still eligible for the insurance requested. Also, spouse coverage will not become effective if insurance on my life is not in effect under an OMA plan issued by New York Life. However, the exception will not apply if it is determined by New York Life that I (the member) am not insurable.

*Residents of Quebec are eligible if: 1) they practice or study outside of Quebec but still reside in Canada; 2) the application was signed in a province or territory other than Quebec and 3) the certificate and all other communications are delivered in a province or territory other than Quebec.

I understand that Interim Insurance is subject to the terms and conditions of the INTERIM INSURANCE AGREEMENT which is attached to this form and which I will detach and keep until an underwriting decision is made. **NOTE: Interim Insurance does NOT apply to Accidental Death & Dismemberment Coverage.**

With respect to this application under this insurance coverage, I authorize New York Life Insurance Company, its subsidiaries, agents, OMA Insurance/ Group Plan Administrator, reinsurer and service providers to use, obtain and exchange relevant information about me, for the purposes of underwriting, administration and adjudicating claims, with any person or organization including health professionals, physicians, medical practitioner, hospital, medical or medically related facility, pharmacy benefit manager, institutions, investigative agencies, MIB, Inc. or insurers about the physical and mental health of any person proposed for insurance including significant history, findings, prescription drug records and related information, diagnosis and treatment. I authorize New York Life Insurance Company to obtain from any government agencies any motor vehicle records necessary. I also authorize New York Life Insurance Company, its subsidiaries, agents, and OMA Insurance/Group Plan Administrator to use and exchange information with OMA Insurance for the purpose of administration. New York Life, its subsidiaries, agents, OMA Insurance/Group Plan Administrator may also release information to those I subsequently authorize in writing. This Authorization may be used for a period of two years from the date signed below. A photocopy of this request form shall be as valid as the original. I know that I may request a copy of this Authorization.

As the spouse of a member, I authorize New York Life Insurance Company, its subsidiaries, agents, OMA Insurance/Group Plan Administrator, reinsurer and service providers and their respective successors to disclose information in this Application, including information regarding my health, to the member for the purposes of managing and reporting on this insurance.

Signed at:	City	Province	Day Month Year

Member's Signature	Spouse's Signature (necessary only if spouse coverage is requested)

Owner's Signature (necessary only if owner is other than member)	SOURCE CODE:

Underwritten by New York Life Insurance Company, Canadian Chief Agency, Toronto, Canada M5H 3C2
For 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.

Return original completed form to: OMA Insurance, P.O. Box 365 Stn Waterloo, Warterloo, ON N2J 4A4

Please read carefully and keep for your records

INTERIM INSURANCE AGREEMENT

New York Life Insurance Company ("New York Life") will provide interim insurance to you, the eligible member or your eligible spouse proposed for insurance ("Applicant") that has included payment with the Request For The Ontario Medical Association Group 10 or 20 Year Level Flex-Term Life Insurance Plan ("Request"), in accordance with the terms of the Request and subject to the following terms and conditions of this Interim Insurance Agreement:

Interim Insurance: NOTE: Interim Insurance does NOT apply to Accidental Death & Dismemberment Coverage.

Interim Insurance on an Applicant commences on the later of: (a) the date the Applicant signs the completed Request; (b) the date the payment is authorized by your bank or financial institution; (c) the date the Applicant becomes a member of an eligible association/society provided it is in within 30 days of the date of this application and provided that an Applicant Spouse (if requesting interim coverage) must be an eligible spouse on that date.

Payment:

If this form is not complete, signed and received within 30 days of the date the application is signed, along with your pre-authorized debit information, Interim Life Insurance will be null and void from its inception. New York Life shall refund the Payment.

The payment included with the Request must be equal to a minimum of one month's basic premium, calculated using the applicable Select or Standard Premium Rate Table. Rates are based upon the Applicant's: age, sex, tobacco/nicotine use, and the amount of insurance requested ("Payment").

Underwriting Requirements:

The Applicant must request Interim Insurance and truthfully answer "No" to the interim insurance health questions on the Request to the best of his or her knowledge and belief.

Amount Of Interim Insurance:

The Interim Insurance provided will be subject to the same provisions, conditions, exceptions, limitations and reductions that would apply had the requested coverage become effective, subject to a maximum amount equal to the lesser of:

(1) the amount of insurance requested on the Request; or
(2) $1,000,000.

Any death benefit payable for the Interim Insurance will be paid in accordance with the Beneficiary Designation made by the Applicant on the Request.

Interim Insurance Ends:

Interim Insurance will terminate on the earliest of the following:

1. The date New York Life approves the Applicant's Request for insurance.
2. 90 days after the date the Request was signed.
3. The date that New York Life mails the Notice that the Request has been declined.
4. The date the Applicant requests New York Life to cancel the Request.
5. The date the Applicant declines New York Life's offer of insurance.
6. The date the Applicant who: (1) applies as an eligible member is no longer an eligible member; or (2) applies as an eligible spouse is no longer an eligible spouse.

Limitations and Exclusions:

a) No waiver of premium benefit is provided under this Interim Insurance Agreement.
b) If the Request is not complete and/or signed by the Applicant(s), then this Interim Insurance Agreement will be null and void from its inception. New York Life shall refund the Payment.
c) New York Life shall have no liability if the Applicant, while sane or insane, commits suicide, except New York Life shall refund the Payment.
d) No Interim Insurance will take effect if:
   i) any question is not truthfully answered "No", or is answered "Yes", or not answered in the Interim Insurance Health Statement;
   ii) the Applicant is neither an Eligible Member nor an Eligible Spouse; or
   iii) payment is not honoured within 30 days of the date of the Request is submitted; or
   iv) there is other New York Life Interim Insurance in effect at the time of this request; or
   v) a material fact has not been disclosed, or has been misrepresented in the Request or any other declaration made in connection to this Request, then this Interim Insurance Agreement will be null and void.

Refund of Payment:

If interim insurance is not payable under this Agreement (except for the reason that coverage has been put in force), New York Life will refund the Payment made with respect to this coverage.

If interim insurance becomes payable under this Agreement, the Payment received will be applied as the first premium for the life insurance applied for. New York Life will refund an appropriate part of the Payment made with respect to the coverage if the liability under this Agreement is less than it would have been under the coverage applied for on the Request.

This Interim Insurance Agreement is entered into by New York Life and the Applicant in Canada and will be subject to all applicable Canadian and Provincial insurance laws.

For 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.

Please read carefully and keep this page for your records

Please read carefully and keep for your records

IMPORTANT NOTICE

How New York Life Underwrites Your Request for Group Life Insurance

Your application for insurance may require New York Life Insurance Company to gather medical and personal information beyond what you provide in the application. This could involve a medical examination, including tests such as that for HIV (AIDS). We may also check finances, hazardous activities, driving records and drug use of the person(s) applying for insurance, and for evidence of any criminal record. If this investigation reveals positive test results for HIV or other communicable or reportable diseases, we will give the results to your doctor if you have authorized us to do so. If we do not have your written authorization, or if we are unable to provide the information to your doctor, we may disclose the test results to the appropriate public health authorities.

In considering whether the person(s) in your request for insurance qualify for coverage, New York Life will rely only on the information you furnish or for which you have provided a specific authorization, including information from MIB, Inc. and on any information we may ask you to obtain from a doctor, hospital etc. New York Life will not disclose such information to anyone unless you authorize it or where required by law. This information may be seen by New York Life, MIB, Inc. and Plan Administrator employees but only on a "need to know" basis in considering your request. We may make a brief report to MIB, Inc., however we will not disclose our underwriting decision. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

MIB, Inc. is a non-profit membership organization of life and health insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB, Inc. member company, medical or non-medical information may be given to the Bureau which on request, may then be furnished to member companies.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Please write to New York Life Insurance Company, Group Membership Association Division, 44 South Broadway, White Plains, NY 10601. Although with the exception of certain jurisdictions, we cannot provide you with any medical information in our files, we will, upon written request, provide such information to a physician you designate. If you question the accuracy of the information provided by MIB, Inc., you may contact MIB, Inc. and seek a correction. The address is MIB, Inc. Information Office 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. The phone number is (416) 597-0590. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective.

Personal Checklist for Mailing

☐ Application for OMA Insurance - Life Insurance ☐ Flex-10 ☐ Flex-20 ☐ Member ☐ Spouse ☐ Member and Spouse

☐ Member Name:

☐ Mailed on:

Reminder: You will be contacted by a service provider on behalf of New York Life to ask about your medical history.