OMA Insurance

Atlantic Benefit Program Enrolment Form

Sun Life

Policy numbers
017884 / 017862

Eligibility

- Physician members in good standing of the New Brunswick Medical Society, the Medical Society of Prince Edward Island or, the Newfoundland and Labrador Medical Association (excluding medical students and residents) who are engaged in providing medical services for at least 15 hours per week on average
- Or a newly retired member of the Atlantic Associations/Societies who is able to perform the Activities of Daily Living (ADL's)
- Under age 79 for Health/Health Plus and Dental/Dental Plus
- Under age 65 for Group Critical Illness (CI)

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 Sun Life Assurance Company of Canada, a member of the Sun Life group of companies.

1 Your information

Please complete all fields.

Ref # (if known)

First name	Middle initial	Last name

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 number	Fax	Email address

For Critical Illness premium determination, 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

I am a member of ☐ NBMS ☐ NLMA ☐ MSPEI

2 Member benefit selection

For Health, Health Plus, Dental and/or Dental Plus coverage, select one of the following:

Single: coverage for you alone

Couple: coverage for you and your spouse

Single plus one Dependent child: coverage for you and one dependent child

Family: coverage for you and two or more family members (includes spouse and dependent children)

Under age 65

• **Member Critical Illness insurance $50,000*** • **Health insurance**** ☐ Single ☐ Couple ☐ Single plus one dependent child ☐ Family ☐ I would like to upgrade to Health Plus coverage.	• **Optional coverage, select one:** ☐ **Dental insurance** ☐ **Dental plus insurance** ☐ Single ☐ Couple ☐ Family

Age 65 and over

• **Health insurance**** ☐ Single ☐ Couple ☐ Single plus one dependent child ☐ Family ☐ I would like to upgrade to Health plus coverage.	• **Optional coverage, select one:** ☐ **Dental insurance** ☐ **Dental plus insurance** ☐ Single ☐ Couple ☐ Family

*Critical Illness insurance is not available if 1) you were previously approved for OMA Critical Illness coverage and did not provide proof of good health or 2) have been paid an OMA Critical Illness claim or have an OMA pending Critical Illness claim.

** Health insurance is not available if you have existing OMA Health insurance inforce.

DC-101

Advisor name

Source code WEB

3 Spouse benefit selection

Available if both Member and Spouse are under age 65 and if Member is applying for Critical Illness coverage

☐ Spouse Critical Illness insurance $50,000*
Has your spouse used tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the last 12 months? ☐ Yes ☐ No

*Critical Illness insurance is not available if 1) you were previously approved for OMA Critical Illness coverage and did not provide proof of good health or 2) have been paid an OMA Critical Illness claim or have an OMA pending Critical Illness claim.

4 Dependent information

Complete if you checked Couple, Single 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	
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female	Student ☐ Yes ☐ No
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female	Student ☐ Yes ☐ No
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female	Student ☐ Yes ☐ No
Child's first name	Middle initial	Last name	Date of birth (dd-mm-yyyy) — —	☐ Male ☐ Female	Student ☐ Yes ☐ No
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 Occupational information

Your medical specialty	Your spouse's occupation (if applying)
Are you actively at work for at least 15 hours per week? ☐ Yes ☐ No	Is your spouse actively at work for at least 15 hours per week? ☐ Yes ☐ No
If "No", do you have any restrictions that prevent you from performing all the usual duties of your occupation? ☐ Yes ☐ No	if "No", does your spouse have any restrictions that prevent your spouse from performing all the usual duties of their occupation? ☐ Yes ☐ No

6 Premium payments – pre-authorized debit (PAD)

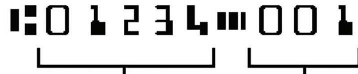
There are no additional charges for paying on a monthly basis – the annual premium is simply divided by 12 months.

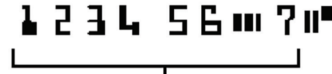
Payment options

☐ Annually, 1st of January

☐ Monthly, 1st day of the month

PLEASE ENTER YOUR BANKING INFORMATION IN THE SPACES PROVIDED.





Transit # Institution # Account #

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

6 Premium payments – pre-authorized debit (PAD) (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 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 January 1 each year. 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 the OMA Insurance/Group Plan Administrator is unable to make a withdrawal from your account.

This PAD 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*

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) – –

7 Declaration and authorization

* Residents of Quebec are eligible if 1) they practice outside of Quebec but still reside in Canada; 2) the Application 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.

I declare that my answers in this enrolment form are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application will cause the insurance to be void.

As a member of the Newfoundland and Labrador Medical Association, New Brunswick Medical Society or Medical Society of Prince Edward Island, I understand and agree that this application is void unless I reside in Canada* on both the date of this application and on the effective date of coverage.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for the purposes of underwriting, administration and adjudicating claims and to use and exchange information with OMA Insurance for the purpose of administration under this benefit program.

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

Signature of member/employee		Signature of spouse (if applying for coverage)
X		X
Location signed (city)	Location signed (province)	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 along with a copy of your void cheque to:
1-800-367-0813
For more information or if you have any questions please:
call 1-800-758-1641

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*.