Manulife

OMA Ontario Medical Association

NEW YORK LIFE

Send completed form to:
Manulife
P.O. Box 17001, Stn Waterloo
Waterloo, ON N2J 0G5

For more information, visit:
omainsurance.com

For questions, please call:
1-888-596-8881

Essentials application for Residents

Disability Insurance and Life Insurance

For the members of the Ontario Medical Association (OMA), and Atlantic Medical Associations or Societies (PTMA). In this application, *we, us,* and *our* refer to The Manufacturers Life Insurance Company (Manulife). *You, your,* and *I* refer to the person applying for insurance.

1 Member information

Residents of Quebec are not eligible for coverage.

OMA member ID #	PTMA member ID # (if applicable)	Advisor name (if known)	Policy #
			OMA-140004 **OMA-G-29500**

1.

Last name	First name	Middle initial

Former name (if applicable)

Place of birth (province, country)	Date of birth (dd/mmm/yyyy)	Sex
		◯ Male ◯ Female

Home address (street number and name)	Apartment or suite

City/Town	Province	Postal code

Telephone (preferred contact)
◯ Home ◯ Business ◯ Cell ( )

Email (optional) By providing us your email you are authorizing us to communicate with you by email for business purposes.

If you are not a member, please contact your provincial medical association/society to arrange for membership.

2. Which provincial medical association or society are you a member of for insurance eligibility?

◯ Ontario Medical Association (OMA)
◯ Medical Society of Prince Edward Island (MSPEI)
◯ Doctors Nova Scotia (DNS)
◯ New Brunswick Medical Society (NBMS)
◯ Newfoundland and Labrador Medical Association (NLMA)
◯ No membership

3. Have you smoked or used cigarettes, e-cigarettes, vapes, cigars, cigarillos, chewing tobacco, nicotine substitutes (such as gum or patches), shisha or hookah pipe, betel nuts, or nicotine or tobacco in any other form in the past 24 months?

◯ Yes ◯ No

2 Coverage details

For more details about the terms of coverage and definitions of riders, please visit: omainsurance.com

1. **Disability Insurance (DI) - 90 day elimination period**

a) ◯ If *yes*, complete the rest of this question. ◯ If *no*, go to question 2.

Amount of monthly benefit applied for, in increments of $100. Minimum of $500, up to a maximum of $4,500 from all sources.

Amount
$

This is the amount of coverage that OMA recommends for Residents. If you are interested in a lower monthly benefit amount please contact the OMA insurance team.

b) **Select the premium rate:**

◯ Level ◯ Step ▸ If you do not check a box, we will consider the premium rate as Step.

Step Rate Premium automatically increases at ages 30, 35, 40, 45, 50, 55 and 60 starting the September following attainment of age. These increases are designed to keep costs lower during the early years when risk of becoming disabled is lower.

Level Premium Rates have been designed to remain level over time as you age and cannot be adjusted on an individual basis due to changes in your age or health. Level Premium Rates may change from time to time on a group basis depending on the insurance costs of the group.

You must reside in Canada, excluding Quebec, in order to apply for the Disability Guaranteed Insurability Benefit rider or exercise a Disability Guaranteed Insurability Benefit rider option.

c) **Select any optional riders:**

☐ $500 Retirement Protection Rider
☐ Cost of living adjustment (COLA)
☐ Guaranteed Insurability Benefit
☐ Own occupation

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

2 Coverage details *(continued)*

The total amount of OMA life coverage under Policy G-29500 obtained without medical questions cannot exceed $200,000. The amount of OMA life insurance issued under this policy will be reduced by any other in force OMA life coverage obtained without medical questions.

A dependent child is your natural child, stepchild or legally adopted child, of you and your legal or common-law spouse, who is not married or in any other formal union recognized by law: who may or may not reside with you but is fully dependent on you for support; who is in your care and custody, residing with you and being fully dependent on you for support; and is under age 25.

2. **Term Life Plus 75 life insurance - $200,000**

If you want less than $200,000 life insurance, or need to speak to an OMA Insurance advisor to review your life insurance needs, please contact OMA insurance.

a) ◉ If *yes*, complete the rest of this question. ◯ If *no*, go to section 3.

Note: This offer does not include the optional waiver of premium rider or the Accidental Death and Dismemberment (AD&D) rider.

b) **Child dependent rider**

◉ If *yes*, complete the rest of this question. ◯ If *no*, go to next question.

Amount requested can be selected in $1,000 increments up to $20,000 and may not exceed 10% of your coverage. Your dependent may not be eligible for this coverage if they are already insured under this policy or under policies G-29700 or G-29800 as your or your spouse's dependent. The Member (or Owner) are automatically assigned as the beneficiary unless someone else is designated.

Amount
$

Child's last name	Child's first name	Middle initial	Date of birth (dd/mmm/yyyy)	Sex
				◯ Male ◯ Female
				◯ Male ◯ Female
				◯ Male ◯ Female

c) **Member beneficiary designation**

You can name who you want to receive the death benefit in the space provided. If no beneficiary is designated, death benefits are paid to your estate. Please contact Manulife for beneficiary changes on any OMA life insurance.

Name (Last, first, initial)	Relationship to you, the member	Date of birth (dd/mmm/yyyy)	% of benefit
			50
			50

d) If any designated beneficiary is a minor when the death benefit is paid, they will be paid into court or to the Public Trustee, unless you appoint a trustee. If you appoint a trustee, benefits are paid to the assigned trustee to hold in trust for the minor beneficiary until they come of age.

Trustee information

Name (Last, first, initial)	Relationship to the beneficiary	% of benefit

e) Is your spouse also a physician? ◯ Yes ◯ No ◯ I do not have a spouse

If *yes*, name of spouse (Last, first, middle initial)

You are not eligible for this offer if you are already insured as a spouse under Policy G-3900, G-29500, G-29700 or G-29800 issued by New York Life.

3 Other insurance information

Do not cancel existing coverage until the coverage you have applied for has been approved.

1. Other than any OMA disability insurance provided by Manulife or PARO, Maritime Resident Doctors or PARNL coverage, do you currently have or have you applied for any disability insurance from any other company or association?

◯ If *yes*, complete question 2. ◯ If *no*, go to section 4.

2.

Name of insurance company or association and policy	Amount of monthly benefit	Pending	Date issued (mmm/yyyy)	Taxable benefit?	Elimination period	Benefit period	Are you replacing coverage?
	$	◯ Yes ◯ No		◯ Yes ◯ No			◯ Yes ◯ No
	$	◯ Yes ◯ No		◯ Yes ◯ No			◯ Yes ◯ No
	$	◯ Yes ◯ No		◯ Yes ◯ No			◯ Yes ◯ No

4 Occupation information

1. Location of your residency (hospital and city)

2. Medical specialty

Date you started your program (dd/mmm/yyyy)	Date you expect to complete your current program (dd/mmm/yyyy)

3. a)

Average number of hours worked per week	If less than 25 hours, please explain

b) If you are on parental leave, please provide the date you will be actively at work full-time.

Date (dd/mmm/yyyy)

4.

Number of weeks worked per year	If less than 46 weeks, please explain

5 Medical questionnaire for Disability Insurance

Do not tell us about genetic testing or genetic test results.

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*, provide location of affected bone, joint, tendon, muscle, or limb

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

6 Payment information

Paying by credit card

The security of your personal information is important to us.

After your policy is approved and inforce, you can change your frequency and/or form of payment. Refer to your welcome package for instructions.

Do not mail a payment with this application.

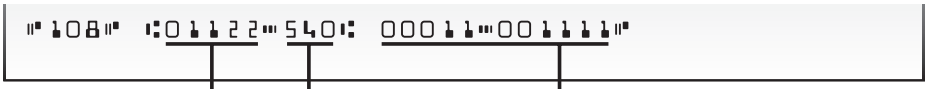
1. Select payment frequency

◯ Annually, September 1st ◯ Monthly, 1st of each month - Based on annual premium divided by 12 - no additional cost

2. Select payment method

◯ I authorize Manulife to use my existing PAD bank information from my current OMA insurance.

◯ I authorize Manulife to use my bank information as follows:



Transit number **Institution number** **Account number**

Your Transit #	Institution #	Account #

3. 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/mmm/yyyy)	Relationship to you		
Address (street number and name)		Apartment or suite	
City/Town	Province	Country	Postal code

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:

Non-chequing accounts: Approval from the financial institution is required for pre-authorized payments from accounts with no chequing privileges, so prior arrangements have been made to allow for pre-authorized payments from the account. Enclosed is a withdrawal slip that has been stamped by the financial institution allowing withdrawals to be made from the non-chequing account.

Payment authorization for PAD payment options

You authorize Manulife to collect the monthly or annual premium (including applicable provincial) tax for this insurance through PAD. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services as defined by Payments Canada in Rule H-1. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. You agree to waive the requirement that Manulife notify you of any payments after the first payment whether the amount of the monthly/annual premium is changed or not. You understand that the monthly premium is due the first of each month and annually on September 1st. This PAD agreement will be cancelled automatically if Manulife is unable to make a withdrawal from your account. This authorization is to remain in effect until Manulife has received written notification from you of its change or termination. This notification must be received at least 10 business days before the next debit is scheduled. You understand that cancelling this PAD agreement may result in loss of insurance coverage unless Manulife receives another form of payment. 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 payments.ca. Manulife 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. For more information about your recourse rights, contact your financial institution or visit payments.ca.

For further information about this authorization, contact:
Manulife
P.O. Box 17001, Stn Waterloo, Waterloo, ON N2J 0G5
Telephone: 1-888-596-8881

4. **Account holder(s) – Please complete and sign**

Account holder name (full name or corporation/entity name)	Account holder address, if different from applicant
Signature of account holder (if business, authorized person to sign and indicate title) ✘	Date signed (dd/mmm/yyyy)
Joint account holder last name	Joint account holder first name
Signature of joint account holder (if both signatures required) ✘	Date signed (dd/mmm/yyyy)

7 Information about MIB, LLC

We consider the information contained in your application to be confidential. However, Manulife or reinsurers involved with your policy may make a report to MIB, LLC (formerly known as the Medical Information Bureau) based on your application, or to other insurance companies to which you apply for life, health or critical illness insurance, or to which a claim for benefits has been made. MIB, LLC is a not-for-profit organization set up by life insurance companies to share information among its members. If you apply for insurance or submit a claim to a member company, MIB, LLC will share any information it has on file.

You may review the information in your file, and request a correction if necessary, by contacting MIB, LLC at:

MIB, LLC
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: (416) 597-0590
Fax: (416) 597-1193
Email: canada_disclosure@mib.com

8 Declaration and authorization

Residents of Quebec are not eligible for coverage.

You hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife) and New York Life Insurance Company (New York Life), under the terms of group insurance policies issued to the Ontario Medical Association (OMA). You declare that the statements contained in this application are true and complete and, together with any other forms signed by you in connection with this application, form the basis for any coverage issued hereunder. You understand that any material misrepresentation shall render the insurance voidable at the instance of the insurer.

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, you understand and agree that this application is void unless you are in active medical training in Canada and reside in Canada, on both the date of this application and on the effective date of coverage. Residents of Quebec are not eligible for coverage.

You understand that you are applying for Disability Income insurance under Group Policy No. OMA 140004 issued by Manulife and/or Life insurance under Policy G-29500 issued by New York Life. Both policies have been issued to the OMA as the group policyholder. 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's insurance business in Canada.

You 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.

You understand that there are exclusions and limitations on the coverage applied for. Relative to the insurance applied for, you hereby authorize Manulife, the plan administrator, New York Life, OMA, the group policyholder and OMA Insurance Inc. (OMAI), a licensed insurance agency, and their authorized staff, agents, representatives, advisors, and service providers to collect, use and exchange information, for you and any covered dependents, needed for underwriting, financial management, administration, and adjudication of claims with each other and any person or organization who has any records or knowledge of you or your health including OMA, OMAI, any licensed physician, medical practitioner, hospital, pharmacy, clinic, or other medically related facility, insurance company, MIB LLC, the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker, or market intermediary, any government agency. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. You confirm that if you are providing personal information related to your spouse or child(ren) that you have the authority to collect and provide such information and for Manulife and the other organizations referenced above to access the information for the purposes specified.

You hereby certify that you have read and understood the MIB, LLC (formerly the Medical Information Bureau), notice in this application, and you have, by your signature below, authorized the MIB, LLC to give to Manulife, or its reinsurers, any information it may have.

A photocopy of this signed authorization shall be as valid as the original.

You acknowledge your receipt of, and agreement with the Information about MIB, LLC, and Manulife's Personal Information Statement found at section 9 of this application. You also acknowledge and agree that any personal information that is collected or used by New York Life, OMA or OMAI is subject to the terms of their respective privacy policies which are available at newyorklife.com, oma.org and omainsurance.com. In the event that OMA, the group policyholder, elects to appoint another plan administrator or insurance carrier to administer or underwrite the insurance provided under either group insurance policy, you consent to having your information transferred to the replacement administrator or underwriter in order to ensure that your benefits and coverage continue uninterrupted.

If your application is approved, you will receive a certificate specifying the coverage provided and the main certificate provisions.

Signed at (city/town, province)	Date (dd/mmm/yyyy)
Signature of applicant ✘	

9 Personal information statement

In this statement, "you" and "your" refer to the policyowner or holder of rights under the contract , the insured and the parent or guardian of any child named as insured who is under the legal age for providing consent. "We", "us", "our" and "the company" refer to The Manufacturers Life Insurance Company (Manulife) and our affiliated companies and subsidiaries.

Updates to this statement and further information about our privacy practices are posted to manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this personal information statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, or driver's license
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test
- Your personal information from MIB LLC., as explained in *Information about MIB LLC*
- A copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or a consumer report from other organizations, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics, and interests
- Banking and employment data to administer benefits
- Other personal information we may require to administer our business relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company,
- Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your policy now, and in the future
  - Public sources, such as government agencies, and internet sites
  - Health Care Professionals, including Medical Practitioners, health care institutions, pharmacy and any other medically-related facility
  - Other insurance carriers
  - Administrators of government benefits and other benefit programs

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents and representatives
- Your advisor and any agency which has entered into an agreement with us and has supervisory authority, directly or indirectly, over your advisor, and their employees
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

How long do we keep your information?

The longer of:

- The time period required by law and by guidelines set for the financial services industry, and
- The time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care centre at 1-888-596-8881, or write to the Privacy Officer at the address below.

Accuracy and access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question, a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to: **Privacy Officer, Manulife, PO Box 1602, 500 King Street N., Waterloo, ON N2J 4C6**.

Canada_privacy@manulife.ca

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Underwritten by The Manufacturers Life Insurance Company (Manulife)

Group Term Life Insurance under Policy G-29500 is 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.