Manulife

OMA Ontario Medical Association

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

Application for change

for OMA Critical Illness or Disability Insurance plans

Use this application if you are applying for reinstatement of coverage; reconsideration of exclusions, and/or change to non-smoker rates; addition of riders to Critical Illness or Disability insurance plans.
In this application, *we, us,* and *our* refer to The Manufacturers Life Insurance Company (Manulife). *You, your,* and *I* refer to the plan member.

1 Applicant information

Residents of Quebec are not eligible for coverage.

OMA member ID #	PTMA member ID # (if applicable)	Certificate/Policy #

1.

Last name	First name	Middle initial

Sex	Date of birth (dd/mmm/yyyy)	Province of birth	Country of birth
◯ 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 contact your provincial medical association or 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 last 24 consecutive months?

◯ Yes ◯ No

2 Requested changes to your policy (if allowed by plan)

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

Plans requested to be changed:

◯ Critical Illness – Complete all questions in sections 3, 4, 5 and 6, except for questions 4.6, and 6.4 to 6.14.
◯ Disability – Complete all questions in sections 3, 4, 5 and 6, except for questions 6.12 to 6.14.
◯ Professional Overhead Expense – Complete all questions in sections 3, 4, 5 and 6, except for question 6.11.
◯ Other: Complete all questions in sections 3, 4, 5 and 6.

_____

Changes requested:

◯ Reinstatement
◯ Non-smoker rates
◯ Increase Retirement Protection Rider from $ _____ to $ _____
◯ Reconsider exclusion
◯ Other: _____

Add a riders:

◯ Retirement Protection Rider
◯ Cost of Living Adjustment (COLA)
◯ Own Occupation
◯ Guaranteed Insurability Benefit
◯ Other: _____

3 Personal information

Please answer all questions and provide full details, or attach a separate sheet, signed and dated.

		Yes	No
3.1	Have you ever applied for any insurance that was declined, modified, or rated? If *yes*, give details including date, name of company and reason:	◯	◯
3.2 a)	In the past five years, have you been charged with or convicted of careless or dangerous driving or had your licence suspended or revoked? If *yes*, provide details, including the number of charges and convictions and date of last conviction. In case of a licence suspension or revocation, provide details including date the licence was suspended or revoked:	◯	◯
b)	Within the past two years, have you been charged with or convicted of two or more moving or traffic violations (for example, speeding, failure to stop, seat belt violations, distracted driving, failure to provide a breathalyzer sample, or operating a vehicle either while impaired by alcohol or drugs or with a blood alcohol level over the legal limit)? If you answered *yes* to a) or b) above, please provide full details: nature of offences, dates, driver's licence number and licensing province:	◯	◯
3.3	Have you any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing, backcountry snow sports, or any other hazardous activity? If *yes*, give details including type of activity and dates:	◯	◯
3.4 a)	Within the next twelve months, do you expect to travel outside Canada and the United States of America? If *yes*, give details including where, when, why, and for how long:	◯	◯
b)	Do you expect to change your country of residence? If *yes*, provide details, including where you intend to move, when you are moving, why you are moving, and if your occupation is changing:	◯	◯
3.5 a)	In the last 10 years, have you used or smoked any form of tobacco or tobacco cessation products, including nicotine substitutes (such gum or patches) e-cigarettes and vaporizers? If *yes*, provide details:	◯	◯

Product type	Date last used:

3 Personal information *(continued)*

Please answer all questions and provide full details, or attach a separate sheet, signed and dated.

	Yes	No
3.6 In the last two years, have you used any drugs for other than medical purposes, used cannabis or hashish (smoked, ingested or vaped); or been advised, treated or counselled for drug abuse? If *yes*, give details including drug used, frequency of use, and dates of last use:	◯	◯
3.7 In the last five years, have you used any drugs other than prescription drugs and/or over-the-counter drugs or used drugs other than as prescribed (including ecstacy, cocaine, narcotics, LSD, heroin, amphetamines, barbiturates, anabolic steroids, or other similar agents)? If *yes*, give details, including what drugs you used, how often, and the last time you used it.	◯	◯

3.8 a) Do you currently drink alcohol?

◯ Yes If *yes*, provide details:

Beer ____ bottles per ◯ day ◯ week ◯ month ◯ year

Wine ____ glasses per ◯ day ◯ week ◯ month ◯ year

Liquor ____ oz/ml per ◯ day ◯ week ◯ month ◯ year

◯ No If *no*, describe any past drinking behaviour, including why you stopped drinking.

b) Have you ever been treated or counselled for alcohol or drug abuse, or has someone ever recommended that you seek treatment or counselling or reduce your alcohol or drug consumption? If *yes*, please provide details.	◯	◯
3.9 Within the past five years have you been convicted with any criminal offense or are you currently charged with one? If *yes*, please provide details, including the nature of each offence, the dates charged, the sentence and the dates the sentence and any probation was completed:	◯	◯
3.10 Within the past five years have you declared, or are you contemplating personal or business bankruptcy? If *yes*, provide details including date of discharge:	◯	◯

4 Your health declaration

Important: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests. Genetic tests are tests that analyze DNA, RNA, or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis, or prognosis.

Please answer all questions and provide full details, or attach a separate sheet, signed and dated.

4.1

Your regular family doctor's name or clinic	Telephone number
Address (street number and name)	

4.2 Date, reason and result of last consultation, and if any treatment or medication prescribed

4.3 Height ◯ ft/in ◯ cm Weight ◯ lbs ◯ kg

4.4 Has your weight changed by more than 10 pounds (4.5 kg) in the past 12 months? ◯ Yes ◯ No

If *yes*: ◯ Gained: ◯ lbs ◯ kg ◯ Lost: ◯ lbs ◯ kg

Reason for change:

4.5 **Have you ever had any indication of or been treated for conditions involving any of the following. If *Yes*, please give details, including the name of the disorder, date of diagnosis and duration, medications or treatment prescribed (if none, state "none"), current status of the condition, as well as the attending physician or hospital.**

	Yes	No
a) **Your heart or blood vessels,** such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	◯	◯
b) **Your nose, throat, or lungs,** such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	◯	◯
c) **Your abdominal organs,** such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	◯	◯
d) **Your kidneys, bladder, or reproductive organs,** such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	◯	◯
e) **Your breast,** such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	◯	◯

4 Your health declaration *(continued)*

4.5 **Have you ever had any indication of or been treated for conditions involving any of the following. If *Yes*, please give details, including the name of the disorder, date of diagnosis and duration, medications or treatment prescribed (if none, state "none"), current status of the condition, as well as the attending physician or hospital.**

	Yes	No
f) **Your brain or nervous system,** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness or tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	◯	◯
g) **Your eyes or ears,** such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	◯	◯
h) **Your mental health,** such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	◯	◯
i) **Your blood or glands,** such as: diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	◯	◯
j) **Your muscles, bones, or joints,** such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	◯	◯
k) **Your skin, such as:** basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions, freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	◯	◯
l) **Your immune system,** such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	◯	◯
m) **Cancer, cysts, lumps, polyps, or tumour?**	◯	◯
n) **Other illness or disorder not mentioned above,** or are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	◯	◯

4 Your health declaration *(continued)*

4.5 **Have you ever had any indication of or been treated for conditions involving any of the following. If *Yes*, please give details, including the name of the disorder, date of diagnosis and duration, medications or treatment prescribed (if none, state "none"), current status of the condition, as well as the attending physician or hospital.**

	Yes	No
o) **If female: Are you currently pregnant?** If *yes*, give due date (dd-mm-yyyy):	◯	◯
i) What was your pre-pregnancy weight? ◯ lbs ◯ kg		
ii) Have there been any complications with your pregnancy? If *yes*, provide details:	◯	◯

4.6 **During the past five years, have you:**

	Yes	No
a) Been told you had, or been investigated or treated for, conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain sciatica, or other?	◯	◯
b) Had x-rays (including of the spine or joints), an electrocardiogram (ECG), blood test, or other diagnostic test?	◯	◯
c) Been advised to have any diagnostic test, consultation, hospitalization, or surgery which has not been completed?	◯	◯
d) Been hospitalized or been medically disabled for more than two consecutive weeks?	◯	◯
e) Consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	◯	◯

4.7 **Within the past two years, have you:**

	Yes	No
a) Had an abnormal mammogram, PSA, or any other test or investigation?	◯	◯
b) Consulted a specialist, been prescribed medication, other treatment or counselling for any disorder other than minor ailments (colds, flu, etc.)?	◯	◯

4 Your health declaration *(continued)*

4.7 **Within the past two years, have you:**

	Yes	No
c) Been advised to undergo further investigation, see another doctor, or have surgery?	◯	◯
d) Or are you currently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	◯	◯

5 Your family history

	Yes	No
5.1 a) Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 70 with heart disease, stroke, or cancer?	◯	◯
b) Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, or retinitis pigmentosa?	◯	◯

If *yes*, to a) or b) above, please complete the following:

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause (if applicable)

6 Financial information

6.1 What is your occupation?

6.2 What is your annual earned income (income after expenses and before taxes)?

6.3 What is your net worth (assets minus liabilities)?

Please complete the following questions if you are applying for reinstatement or change to a Disability policy and/or a Business Expense policy.

6.4 Are you licensed to practice medicine by the College of Family Physicians of Canada (CFPC/CCFP) or the Royal College of Physicians and Surgeons (RCPSCF)? ◯ Yes ◯ No

6.5 Your employment status: ◯ Employee (no ownership) ◯ Self Employed

6.6 Occupational duties: (Give description of duties and percentage of time performing each.)

6 Financial information *(continued)*

6.7 a) If self-employed, what is the organizational structure of your business?

◯ Sole proprietor ◯ Partnership ◯ Corporation If incorporated, give percentage of ownership: %

b) How long have you been self-employed? Since (mm-yyyy):

c) If self-employed less than two years, give details of previous employment history, if any:

6.8 a) How many hours per week do you work?

b) How many weeks per year do you work?

6.9 Do you have any part-time or other full-time jobs? ◯ Yes ◯ No

If *yes*, provide details:

6.10 Do you expect your income or employment situation to change within the next twelve months? ◯ Yes ◯ No

If *yes*, provide details:

6.11 What was your net annual earned income (after regular business expenses but before taxes)?

Last year: $ 2 years ago: $

6.12 a) Other than any OMA disability 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 b). ◯ If *no*, go to the next question.

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

b)

Name of insurance company or association and policy number	Monthly benefit amount	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

Please complete the following questions if your requested changes only apply to a Professional Overhead Expense policy.

6.13 Do you share office expenses? ◯ Yes ◯ No

If yes, what is your percentage share?

6.14 What are your total monthly business expenses?

$

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 if necessary, request a correction by contacting MIB, LLC at:

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.

I hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife), under the terms of group insurance policies issued to the Ontario Medical Association (OMA). I declare that the statements contained in this application, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any coverage issued hereunder. I understand that any material misrepresentation including misstatement of smoker status shall render the insurance voidable at the instance of the insurer. I have read the Pre-Existing Conditions Exclusions and understand that there are exclusions and limitations on the coverage applied for.

Relative to the insurance applied for, I, the undersigned person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB, LLC., the group policy administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose. I authorize Manulife to hold a personal file about myself and my insurance coverage. I authorize Manulife, the plan administrator; and OMA, the group policyholder; and OMA Insurance Inc. (OMAI), a licensed insurance agency; and their authorized staff, agents, representatives, advisors and service providers to use and exchange information needed for underwriting, financial management, administration and adjudication of claims with each other under this insurance coverage with any person or organization who has relevant information about me including OMA, OMAI, any institutions, investigative agencies, insurers, and reinsurers. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. A photocopy or faxed copy of this authorization shall be as valid as the original.

I declare that I have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. I understand that this consent may be revoked at any time and that, if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

I acknowledge my receipt of and agreement with the Information about MIB, LLC, and with Manulife's Personal Information Statement found at section 9 of this application. I 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, I consent to having my information transferred to the replacement administrator or underwriter in order to ensure that my benefits and coverage continue uninterrupted.

Signed at (city/town, province)	Date (dd/mmm/yyyy)

Name of applicant

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, recorded Teleinterviews 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 plan 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)