Manulife

OMA Ontario Medical Association

Send completed form to:
Manulife
P.O. Box 17001, Stn Waterloo
Waterloo, ON N2J 0G5
Or upload at
manulife.ca/secureserve
For more information, visit:
omainsurance.com
For questions, please call:
1-888-596-8881

Application for overage disabled dependant

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

Use this application to request continuation of coverage for a disabled dependant after they reach age 18.

1 Plan member information

Please complete the following.

OMA member ID #		
Plan member last name	First name	Middle initial
Address		
City	Province	Postal code

2 Dependant information

Last name of dependant	First name	Middle initial
Relationship to plan member	Dependant date of birth (dd/mmm/yyyy)	Sex ◯ Male ◯ Female
Address of dependant if different from plan member		
City	Province	Postal code

1. Is the dependant a resident of your home 365 days a year? ◯ Yes ◯ No

   If *No,* please explain. Details

2. Has the dependant ever been employed? ◯ Yes ◯ No

   If *Yes,* list their most recent dates of employment and the type of work.

Start date (dd/mmm/yyyy)	End date (dd/mmm/yyyy)	Weekly hours	Type of employment

3. Has the dependant ever attended school? ◯ Yes ◯ No

   If *Yes,* provide their most recent dates and type of schooling.

Most recent date(s) (dd/mmm/yyyy)	Weekly hours	Type of school

4. Is dependant eligible for:
   a) benefits under a government plan? ◯ Yes ◯ No
   b) Health, Dental, and/or, Disability Benefits from another group plan? ◯ Yes ◯ No

   If you answered *Yes* to either question, provide details here.

   Details

5. Are you the sole means of support for the dependant? ◯ Yes ◯ No

   If *No,* please explain. Details

2 Dependant information (continued)

6. Please confirm if the dependant was covered as an overage dependant under a previous group plan. ◯ Yes ◯ No

If *Yes,* provide details here.

Insurance company	Policy number	Certificate number	Date coverage terminated (dd/mmm/yyyy)

3 To be completed by the attending physician

Physician last name	First name	Middle initial

Physician address	City and province	Postal code

Telephone number	Fax number	Email address
( )	( )	

1. What is the clinical diagnosis, the nature and degree of mental/physical disability? Please provide details.

Details

2. When was the above condition diagnosed?

Date (dd/mmm/yyyy)

3. When was the patient last examined?

Date (dd/mmm/yyyy)

4. How does the mental or physical disability restrict the patient's ability to engage in normal activities?

Details

5. Does the patient need assistance with activities of daily living? ◯ Yes ◯ No

If *Yes,* please provide details.

Details

6. What type of work can the patient perform?

Details

7. Please confirm the dates this patient has been unable to work or attend school full-time due to the disability.

Date(s) (dd/mmm/yyyy)

8. What is the prognosis?

Details

9. Do you consider the patient to be totally disabled? ◯ Yes ◯ No

10. Is the disability ◯ temporary **or** ◯ permanent

11. Are there any additional remarks or observations you can provide?

Details

I DECLARE that the information in this section is true to the best of my knowledge.

Physician signature	Date (dd/mmm/yyyy)

4 Declaration and authorization

- **I hereby** apply for coverage ("Coverage") under the plan issued to my plan sponsor by Manulife.
- **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants").
- **I certify** that the information in this form is true and complete to the best of my knowledge.
- **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge.
- **I acknowledge** and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.
- **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes").
- **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.
- **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes.
- **I agree** a photocopy or electronic version of this authorization is valid.
- **I understand** that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a health file. Access to my Information will be limited to:
  - Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
  - Persons to whom I have granted access; and
  - Persons authorized by law.
- I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.
- **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at manulife.ca/planmember, or from my Plan Sponsor.

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

Underwritten by The Manufacturers Life Insurance Company (Manulife)