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

Life event change form for Health and Dental insurance

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 plan member.

1 Member information

OMA member ID #	PTMA member ID # (if applicable)	Policy # **OMA-17884**
Last name	First name	Middle initial
Former name (if applicable)	Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)
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.		

2 Life event change

[1] Health Insurance:
- Single: coverage for you only
- Single plus one child: coverage for you and one dependent child
- Couple: coverage for you and your spouse
- Family: coverage for you and two or more family members (includes spouse and/or dependent children)

[2] Dental insurance:
- Single: coverage for you only
- Couple: coverage for you and one dependent (spouse or child)
- Family: coverage for you and two or more dependents (includes your spouse and/or dependent children)

You must apply within 90 days of the effective date of the life event change.

Select the applicable option	Your current coverage is:	Your life event is:	You are requesting to change your coverage to:
◯ A	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family Dental insurance[2] ◯ Single ◯ Couple ◯ Family	◯ Marriage ◯ Birth, adoption, accepting legal guardianship of a child ◯ A dependent spouse or child becomes eligible for coverage Date of life event change (dd/mmm/yyyy)	◯ Add a dependent spouse and/or children. Please complete section 3 to provide the details of your dependents. If you'd like to increase your coverage, please complete section 4.
◯ B	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family Dental insurance[2] ◯ Single ◯ Couple ◯ Family	You now have an equivalent extended health care plan. Date of life event change (dd/mmm/yyyy)	You can either: ◯ Keep your current coverage. Please **do not** return this form. **or** ◯ Cancel your policy. Please complete AF1530E, *Cancellation of existing group insurance coverage*.
◯ C **Please note,** if you live in Quebec, regardless of where you practice, you may not request health insurance.	Dental insurance[2] ◯ Single ◯ Couple ◯ Family	You lost health insurance under your or your spouse's insurance plan and are applying for OMA's Health Insurance under Group policy 17884. Date of life event change (dd/mmm/yyyy)	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family If you'd like to increase your coverage, please complete section 4.

Please note: you need to pay the applicable monthly/annual premium for any additional coverage you select.

3 Dependent details

Complete this section if you selected options A or C in section 2, to provide information on the dependents (spouse and/or children) to be covered.

A dependent child is your natural child, stepchild, or legally adopted child, either of you, your legal spouse, or your 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 18 (age 25 if a full-time student), or to any age if mentally or physically disabled.

Last name	First name	Middle initial	Date of birth (dd/mmm/yyyy)	Sex	Student
				◯ Male ◯ Female	◯ Yes ◯ No
				◯ Male ◯ Female	◯ Yes ◯ No
				◯ Male ◯ Female	◯ Yes ◯ No
				◯ Male ◯ Female	◯ Yes ◯ No

If you need more space, please complete on a separate sheet of paper, with the date and your signature.

4 Additional coverage selections

If you selected options A or C in section 2, you can choose your level of health and/or dental coverage in this section.

If you don't wish to make changes to your level of coverage, please do not complete this section.

Additional coverage you can select:

◯ Health Plus
◯ Dental
◯ Dental Plus

Please note:

- Dental and Dental Plus are only available to members under age 79. No medical evidence required.
- If you live in Quebec, regardless of where you practice, and don't already have some level of dental insurance, you may not add Dental or Dental Plus coverage.

5 Declaration and authorization

I declare that my answers in this 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 Ontario Medical Association, Newfoundland and Labrador Medical Association, New Brunswick Medical Society, Medical Society of Prince Edward Island, or Doctors Nova Scotia, or as a spouse/employee of a member, I understand and agree that this form is void unless I reside in Canada, on both the date of this form and on the effective date of coverage.

With respect to this form, I authorize The Manufacturers Life Insurance Company (Manulife), its agents and service providers to collect, use and disclose relevant information needed for the purposes of underwriting, administration and adjudicating claims with any person or organization who has relevant information about me including health professionals, institutions, the MIB, investigative agencies, insurers and reinsurers; and to collect, use, and disclose information to OMA Insurance for the purpose of administration.

A photocopy of this authorization is as valid as the original.

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

Signature of member/employee	Signature of spouse (if applying for coverage)
✘	✘

The Manufacturers Life Insurance Company (Manulife)