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 the Physician Health Benefit Program (PHBP)

delivered by OMA Priority Insurance Program (OPIP)

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

1 Member information

Residents of Quebec are not eligible for coverage.

OMA member ID #	PTMA member ID # (if applicable)	Policy #
		OMA-50131

Last name	First name	Middle initial	Sex
			◯ Male ◯ Female

Former name (if applicable)	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 Applying for changes to government subsidized PHBP benefits

[1] Health Insurance: an applicant who was previously declined as a member or spouse/dependent under any OMA Health Insurance may not be eligible for PHBP Health coverage.

- 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] Health Care Spending Account is only available to members who have an equivalent Health Insurance plan and wish to opt out of Health Insurance coverage.

- Under age 65 - $350
- Age 65 and over - $500

You must apply within 90 days of the effective date of the life event change. These changes are for the Health Insurance portion of your OPIP coverage only. Your Critical Illness Insurance coverage of $50,000 remains in place.

Select applicable option(s)	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	◯ Marriage ◯ Birth, adoption, or accepting legal guardianship of a child ◯ A dependent spouse or child becomes eligible for coverage Date of life event change (dd/mmm/yyyy)	Add dependent spouse and/or children. If applying for self-funded options, please complete Section 4.
◯ B	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family	You now have an equivalent extended health care plan and wish to opt out of Health Insurance coverage. Date of life event change (dd/mmm/yyyy)	Health Care Spending Account (HCSA)[2]
◯ C	Health Care Spending Account (HCSA)[2]	You lost Health Insurance under your or spouse's insurance plan. Date of life event change (dd/mmm/yyyy)	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family
◯ D	OPIP continuation	You become eligible for the Ministry of Health Long Term Care (MOHLTC) subsidy.	Apply for the MOHLTC subsidy. If you request any additional benefits, medical evidence information may be required.

3 Dependent details

Complete if you checked anything other than Single coverage in Section 2, to provide information on the dependent(s) 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, sign and date it.

4 Additional self-funded options

Monthly or annual premium are applicable/to be paid by member for self-funded options applied for.

If you are adding coverage for a spouse or dependent children, please also complete section 3 Dependent details.

PHBP Coverage selected in section 2	Additional coverage you can select
Health	◯ Health Plus ◯ Dental Plus ◯ Dental
Health Care Spending Account	◯ Dental Plus ◯ Dental › ◯ Single ◯ Couple ◯ Family

Note: Dental and Dental Plus are available only to members under age 79. No medical evidence required.

5 Application for subsidy

Choose only **one** option.

1. ◯ **I am applying for the Ministry of Health Long Term Care (MOHLTC) subsidy**

I understand and acknowledge that the payment of the Physician Health Benefit Program (PHBP) premium is my obligation and that this obligation, less my OPIP annual contribution, will be discharged by the subsidy provided through the Ontario Physicians Services Inc. (OPSI) to Manulife. Furthermore, I understand and acknowledge that any subsidy provided through OPSI for my coverage under this benefits program may be considered income that must be reported by me for income tax purposes. Each year, to assist in that reporting, OPSI will issue a premium summary statement to me.

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

Signature of member

✘

If your professional corporation is applying for the MOHLTC subsidy, please provide your corporation's name.

2. ◯ **My professional corporation is applying for the Ministry of Health Long Term Care (MOHLTC) subsidy**

Corporation name

I understand and acknowledge that the payment of the Physician Health Benefit Program (PHBP) premium is my obligation and that this obligation, less my corporation's obligatory OPIP annual contribution, will be discharged by the subsidy provided through the Ontario Physicians Services Inc. (OPSI) to Manulife. Furthermore, I understand and acknowledge that any subsidy provided through OPSI for the individual specified in Section 1 above, for my coverage under this benefits program may be considered income that must be reported by the corporation for income tax purposes. Each year, to assist in that reporting, OPSI will issue a premium summary statement to me.

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

Signature of signing officer

✘

6 Declaration and authorization

Residents of Quebec are not eligible for coverage.

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

I understand that to enrol in this benefits program I must be an *Eligible Physician*, not a resident, who:

1. lives in Canada, but excludes residents of Quebec;
2. is registered with the College of Physicians and Surgeons of Ontario;
3. is engaged in providing medical services in the province of Ontario for at least 15 hours per week on average;
4. is a member in good standing of the Ontario Medical Association or, if not a member, has paid dues and assessments owning under the *Ontario Medical Association Dues Act*, 1991.

I understand and agree that this form is void unless I am an Eligible Physician as defined above.

I understand that if I cease to be an Eligible Physician, I may continue to participate in this benefits program at my own expense, subject to age and certain other restrictions defined by the Program's contracts of insurance.

I hereby agree to advise the program administrator if I am no longer residing in Canada; if I am no longer registered with the College of Physicians and Surgeons of Ontario; if I am no longer engaged in providing medical services in the province of Ontario for at least 15 hours per week, on average; or if I am on a parental leave of absence for more than one year. I understand that if I have any questions about my ongoing eligibility to participate in this benefits program, I should contact the program administrator.

I authorize Manulife, the plan administrator; OMA Insurance Inc. (OMAI); and/or the Ontario Medical Association (OMA), the group policyholder, and its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims, and to use and exchange information with OMAI and/or OMA for the purpose of administration under this benefits program.

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

I and, if applicable, my spouse and/or dependent(s) authorize Manulife and its agents and service providers to use and exchange information about me (and, if applicable, my spouse and/or dependents) needed for underwriting, administering and adjudicating claims under this plan, and to use and exchange information with OMAI, and the OMA for the purpose of administration under this program.

My spouse and/or dependent(s), if applicable, authorize Manulife to disclose information about them to me for the purpose of assessing this application and managing the plan.

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

The Manufacturers Life Insurance Company (Manulife)