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

Plan change form for the Physician Health Benefit Program (PHBP) delivered by OMA Priority Insurance Program (OPIP)

If applying within 90 days after a life event (in Section A-2, options 3 or 4 below), please complete form AF1534E, *OPIP Life Event Change Form* instead.

In this form, *we, us, our,* and *the Company*, refer to The Manufacturers Life Insurance Company (Manulife). *You, your,* and *I* refer to the plan member applying for insurance.

Section A - Member details and plan changes

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

Former name (if applicable)	Sex	Date of birth (dd/mmm/yyyy)
	◯ 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.

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

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:
No medical evidence is required for options 1 and/or 2. Proceed to Section C.			
◯ 1	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]
◯ 2	OPIP continuation	You are 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.
Medical evidence is required for options 3 and 4. Please complete all of Section B. If applying less than 90 days after a life event (options 3 or 4 below), please complete form AF1534E, *OPIP Life Event Change Form*.			
◯ 3	Health Care Spending Account (HCSA)[2]	You lost Health Insurance under your or spouse's insurance plan.	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family
◯ 4	Health insurance[1] ◯ Single ◯ Single plus one child ◯ Couple ◯ Family	◯ Marriage ◯ Birth or adoption of a child ◯ Accepted legal guardianship of a child ◯ A dependent spouse or child becomes eligible for coverage	Add dependent spouse and/or children. If applying for self-funded options, please complete Section A4.

3 Dependent details

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.

Complete if you checked anything other than Single coverage in Section 2, to provide information on the dependent(s) to be covered.

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.

Section B - Personal health information

The following personal health information is required as a late entrant for risk assessment.

1 Background information

Please provide details for person(s) applying for coverage.

Please do not complete if applying for Dental/Dental Plus coverage only.

Plan member

Height	Weight	Change in weight in the last 12 months
◯ ft/in ◯ m/cm	◯ lbs ◯ kgs	◯ No change ◯ Gain _____ ◯ Loss _____ ◯ lbs ◯ kgs

Reason for weight change

Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)

Name of physician, diagnosis, treatment given, results, medication prescribed

If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them

Spouse (if applying for spousal health insurance)

Height	Weight	Change in weight in the last 12 months
◯ ft/in ◯ m/cm	◯ lbs ◯ kgs	◯ No change ◯ Gain _____ ◯ Loss _____ ◯ lbs ◯ kgs

Reason for weight change

Date, reason and results for last consultation with attending physician (if no attending physician, please state **none**)

Name of physician, diagnosis, treatment given, results, medication prescribed

If the physician named above does not have the most complete records of your medical history, please provide full name and address of the physician who does have them

2 Family history information

Have any of you or your spouse's immediate family members (parents, brothers, sisters) had cancer (specify type), heart disease, stroke, diabetes, polycystic or other kidney disease, multiple sclerosis, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease), Muscular Dystrophy, familial polyposis of the bowel, Huntington' s Chorea or any other hereditary disease?

◯ Yes ◯ No If *yes*, complete the chart below.

Plan member's family history

Relation	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

Spouse's family history (if applying for spousal health insurance)

Relation	Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father				
Mother				
Brother(s)				
Sister(s)				

3 Medical and/or treatment information

Within the last 12 months, have any of the persons to be insured taken or been advised to take prescription drugs and/or used devices and/or medical accessories or other treatment (therapy, counselling, etc.) including unfilled prescriptions?

You	Your spouse	Your dependent children
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

If *yes*, please complete the chart below.

Name of person to be insured	Condition	Medication and/or treatment	Monthly cost	Strength	Daily dosage	Length of time

4 Medical information

Have you, your spouse, or dependents ever:	Member Yes	Member No	Spouse Yes	Spouse No	Dependent Yes	Dependent No
a) Had chest pain, heart attack, abnormal electrocardiogram (ECG), high blood pressure, irregular pulse, heart murmur, high cholesterol or any other disease or disorder of the heart or circulatory system?	◯	◯	◯	◯	◯	◯
b) Had a stroke, transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson' s or any other disease or disorder of the brain or nervous system?	◯	◯	◯	◯	◯	◯
c) Had diabetes; impaired fasting glucose, sugar, blood or protein in the urine?	◯	◯	◯	◯	◯	◯
d) Had a disease of the kidneys, urinary tract, bladder, prostate or reproductive organs or had any complications of pregnancy?	◯	◯	◯	◯	◯	◯
e) Had tumours, cancer, polyps or other growth; including breast lumps, cysts or other breast changes, or had an abnormal mammogram?	◯	◯	◯	◯	◯	◯
f) Had moles or other growth or a disorder of the skin?	◯	◯	◯	◯	◯	◯
g) Had a blood or lymph gland disorder; leukemia or any other form of malignant disease; or had a biopsy?	◯	◯	◯	◯	◯	◯
h) Had chronic lung or respiratory disorder; sleep apnea, disease or disorder of the eyes, ears, nose or throat or had loss of speech?	◯	◯	◯	◯	◯	◯
i) Had any disorder of the colon, rectum, intestines, including colitis or disorder of the stomach or digestive system?	◯	◯	◯	◯	◯	◯
j) Had chronic fatigue; neck or back pain; spinal disorder; bone, muscle or joint disorder; fibromyalgia or rheumatic/arthritic disease; or lupus?	◯	◯	◯	◯	◯	◯
k) Had any psychiatric disorder; depression, suicide attempts or ideations, anxiety state or panic attacks; eating disorder; other emotional or psychiatric disorder; or been counselled for such?	◯	◯	◯	◯	◯	◯
l) Had a disorder of the liver including testing positive for hepatitis B, hepatitis C or human immunodeficiency virus (HN); been identified as a hepatitis B carrier or have chronic hepitatis B; been tested for, counselled for or been told you have acquired immune deficiency syndrome (AIDS) or any other immunological disorder?	◯	◯	◯	◯	◯	◯
m) Had any other illness, disease, disorder, condition, injury diagnostic testing or surgical procedure not listed above; had any health symptoms or complaints for which a physician has not been consulted; or been advised to have further examinations or tests which have not yet been completed?	◯	◯	◯	◯	◯	◯
Do you, your spouse, or dependents ever:						
n) Consume alcoholic beverages?						
If *yes*, please record the number of alcoholic beverages consumed in a week:	◯	◯	◯	◯	◯	◯
Within the past 5 years, have you, your spouse, or dependents:						
o) Received advice or treatment for the use of alcohol?	◯	◯	◯	◯	◯	◯
p) Used sedatives, analgesics, hypnotics, tranquilizers and/or stimulants?	◯	◯	◯	◯	◯	◯
q) Used marijuana, hashish, cannabis, cocaine, narcotics, hallucinogens, heroin, barbiturates, or sought or received advice or treatment for the use of drugs, prescribed or non-prescribed or obtained over the counter?	◯	◯	◯	◯	◯	◯

If you, your spouse, or your dependents replied yes to any of the questions (a-q), please provide details below. If the space provided is insufficient, please provide details on a separate, duly signed and dated sheet.

Question	Name of person	Date (dd/mm/yyyy)	Duration	Diagnosis	Treatment	Name and address of physicians, hospitals, insurance companies

Section C - Subsidy, declaration and authorization

1 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 the Company. 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)
Your signature ✘	

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

2. ◯ **My professional corporation is applying for the MOHLTC subsidy**

Corporation name

I understand and acknowledge that the payment of the Physician Health Benefit Program (PHBP) premium is my professional corporation's 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 the Company. Furthermore, I understand and acknowledge that any subsidy provided through OPSI for the individual specified in Section A-1, for 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 ✘	

2 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:

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

3 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 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 hereby cerifiy that I have read section C-2 Information about MIB, LLC., and having read the contents, I have, by the signature(s) below, authorized the MIB to give to Manulife, or its reinsurers, any information it may have.

I authorize Manulife 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 the Ontario Medical Association for the purpose of administration under this benefits program.

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

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

Signature of member	Signature of spouse
✘	✘

The Manufacturers Life Insurance Company (Manulife)