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

Request for change to existing group insurance coverage

For the members of the Ontario Medical Association (OMA), and Atlantic Medical Associations or Societies (PTMA). 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 Member information

Residents of Quebec are not eligible for coverage.

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

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 Type of change request

Use this section to request changes to your current coverage. Please use the Special instructions box to indicate details.

This form can't be used for requests to increase coverage, changes to non-smoker, adding dependents (spouse and/or children), reconsidering exclusions, requesting to reinstate your policy, or banking information updates.

Changes to your coverage. Use the Special instructions box to indicate details.

◯ Remove a spouse and/or dependent children.

Names of spouse and/or dependent children you are removing. _____

◯ Name change. Please complete section 4.

◯ Reduce coverage amount on policy number: _____ from $ _____ to $ _____

◯ Remove policy rider(s). Please use the Special instructions section below to indicate rider details.

◯ Increase elimination period(s) to: ◯ 30 ◯ 60 ◯ 90 ◯ 120 ◯ 180 ◯ 365 days

◯ Change from Health Plus to Health.

◯ Change from Dental Plus to Dental.

◯ Other. Please provide details in the Special instructions box.

Special instructions

Please indicate a current or future date, do not back date. Changes will be effective on the requested date, or the last day of the requested month, whichever is later, provided a minimum of 31 days' notice is given. If a premium is withdrawn in the meantime, a premium adjustment may apply.

Change date: Date (dd/mmm/yyyy)

In addition to this request, are you requesting any changes to your existing insurance coverage with form AF1533E, *Application for change for OMA Critical Illness or Disability Insurance plans*?

◯ Yes ◯ No

2 Type of change request (continued)

Note, a minimum amount of Member Life coverage may be required in order to keep a Spouse Life plan active. Please refer to the terms of your contract for details.

Please indicate each policy number you wish to change.

Member Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Spouse Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Disability	◯ 2718	◯ 59997	◯ 17849	◯ 140004
Member Critical Illness	◯ 17840	◯ 17862		
Spouse Critical Illness	◯ 17840	◯ 17862		
Professional Overhead Expense	◯ 20647	◯ 20638		
Accidental Death and Dismemberment	◯ 95001			
Health/Health Plus	◯ 17884 Plan number:_____ ID number:_____			
Dental/Dental Plus	◯ 17884 Plan number:_____ ID number:_____			
OPIP (all coverage under OPIP will be changed)	◯ 50130/50131 Plan number:_____ ID number:_____			

Policy numbers

- For Health, Dental and OPIP policies, your plan number can be found on the front of your Benefit card.
- For all other policies, you policy number can be found on your Certificate.

3 Reason for change

Please indicate why you wish to change your coverage. Provide any additional details in the space provided.

◯ Cost of coverage
◯ My needs have changed. Please provide details below.
◯ Plan features/service. Please provide details below.
◯ I have obtained new coverage through:
- ◯ My employer
- ◯ Another insurance company
- ◯ Another medical association

Details/comments

4 Name change

Submit the appropriate legal documents if:

- the given name or surname changed for reasons other than marriage, divorce, or adoption
- a company changed its name.

Example:

- Certificate of Amendment
- Supplementary Letters Patent

No documentation is required if the name changed due to marriage, divorce, or adoption.

You are requesting to change the name of the:

◯ Insured person ◯ Policy Owner ◯ Spouse and/or dependent child

From

To

Reason for change:

◯ Marriage ◯ Divorce ◯ Adoption ◯ Other _____

5 Declaration and authorization

By signing below I authorize Manulife to process the requested change(s) outlined above. I understand the implications of the change(s) requested and that Manulife requires at least 10 business days to process coverage requests. All changes are made effective as of the end of the month in which the request is received or the requested date, whichever is later. Once the request has been processed, any premiums owing to me will be refunded, if applicable.

Signature of policy owner	Date (dd/mmm/yyyy)
✘	
Signature of life beneficiary (if irrevocable)	**Signature of assignee (if collaterally assigned)**
✘	✘

The Manufacturers Life Insurance Company (Manulife)