Application for Insurance

ONTARIO PHARMACISTS ASSOCIATION

1.1 Section 1 – Proposed Insured Information (Please print)

Name: Salutation | First Name and Middle Initial | Surname (include maiden name [in brackets], if applicable)

Residence address: Number | Street | Apt/Suite

City | Province | Postal Code

Phone numbers: Residence | Business | Cell

Email Address:

Date of Birth: (Month / Day / Year) Place of Birth:

OPA Member #:

Note: Non-pharmacist/non pharmacy technician applicants must give employer's OPA member number

Occupation: Annual Income:

Are you now actively engaged in your occupation on a full time basis? ☐ Yes ☐ No

If 'no', provide details: Number of hours worked/week:

1.2 Billing Address (if different from above)

Pharmacy Name:

Address: Number | Street | Apt/suite

City | Province | Postal Code

Note: Non-pharmacist/non-pharmacy technician applicants must complete number 1.2

1.3 Status of Proposed Insured

☐ Member Pharmacist ☐ Member Pharmacy Technician ☐ Staff Employee ☐ Member's Spouse

Are you now insured under an OPA life, critical illness or disability plan(s)? ☐ Yes ☐ No

If 'yes', provide: Policy Number(s) | Certificate Number(s)

2.1 Section 2 – Insurance Coverage

Voluntary Accidental Death & Dismemberment – SECTION 8 – agreements and authorizations must be signed

☐ **Without** dependent coverage (single) ☐ **With** dependent coverage (family)

Amount Applied for: $ Quarterly Premium $

Note: Complete the Beneficiary Designation **2.2** below. If you do not complete the beneficiary designation, benefits will be paid to the estate.

2.2 Beneficiary Designation

To be completed for Voluntary Accidental Death & Dismemberment, Term Life, Critical Illness and/or Business Expense Disability

Full first name and last name and of Primary Beneficiary	%	Relationship to Insured

Contingent/Secondary Beneficiary (In the event of Beneficiary pre-deceasing Insured)	%	Relationship to Insured

Name of Trustee (If named beneficiaries are children below age 18)	Relationship to Insured

Note: Beneficiary designation for Quebec resident is irrevocable unless you specifically write "revocable"

FOLLOWING SECTIONS MUST BE COMPLETED IF APPLYING FOR:
Term Life, Critical Illness, Long Term Disability, or Business Expense Disability

2.3 a) Is any **other life, critical illness or disability insurance** application on you now **pending** or **contemplated**? ☐ Yes ☐ No

If 'yes' provide details:

b) Do you have **existing** life, critical illness or disability insurance policies? ☐ Yes ☐ No
If 'yes', please list below:

Amount	Type of Insurance	Company	Year Insured	For Disability:		
				Waiting Period	Benefit Period	Taxable/ Non-taxable

c) Are you replacing existing insurance with this application? ☐ Yes ☐ No

If 'yes' provide details:

2.4 Name of Owner (if different from 1.1) for Term Life only:

Relationship to Proposed Insured:

Contingent Owner (in event of death of Primary Owner):

2.5 Term Life

Amount Applied for: $ Quarterly Premium:

Note: Complete the **Beneficiary Designation 2.2** on page 1. If you do not complete the beneficiary designation, benefits will be paid to the estate.

2.6 Critical Illness

☐ **Basic Only** (4 impairments) ☐ **Basic & Extended** (17 impairments)

Amount Applied for: $ Quarterly Premium:

Note: Complete the **Beneficiary Designation 2.2** on page 1. If you do not complete the beneficiary designation, benefits will be paid to the estate.

2.7 Long Term Disability

Monthly income: $ Amount Applied for $
(monthly benefit)

Please indicate waiting period chosen: ☐ 14 days ☐ 30 days ☐ 120 days

Have you selected the Cost of Living Adjustment Option (C.O.L.A.)? ☐ Yes ☐ No

Quarterly premium amount $

2.8 Business Expense Disability

Amount Applied for $ Quarterly Premium
(monthly benefit)

* If Amount Applied for exceeds $1,500, complete **Section 7**

Please indicate waiting period chosen: ☐ 14 days ☐ 30 days

Note: Complete the **Beneficiary Designation 2.2** on page 1. If you do not complete the beneficiary designation, benefits will be paid to the estate.

3.0 Section 3 – Medical Information

Complete all questions below. Provide full details to 'yes' answers in 3.14 and/or attach separate sheet (signed & dated)

3.1 Your Height ☐ cm ☐ ft/in Your Weight ☐ kg ☐ lbs

In the past year, weight has: ☐ Remained same ☐ Increased ☐ Decreased

How much? Reason for change

3.2 Who is your regular physician or family doctor?

Name Date Last Seen

Address

Reason Last Seen

Result of Consultation

	Yes	No
3.3 a) **In the past 12 months** have you used tobacco in any form (including but not limited to, cigarettes, cigars, pipes, smokeless tobacco, nicotine gum, the nicotine patch or other smoking cessation products)? If 'yes', amount used daily	☐	☐
b) Have you **EVER** been advised to quit smoking for health reasons?	☐	☐
3.4 Have you ever had any indication of or been tested or treated for a disorder of:		
a) lungs—including asthma, bronchitis, emphysema, tuberculosis, pleurisy, chronic respiratory disorder, pneumonia, or sleep apnea?	☐	☐
b) heart—including chest pain, shortness of breath, high blood pressure, Rheumatic fever, palpitations, heart murmur, heart attack, stroke, transient ischemic attack, peripheral vascular disease, phlebitis, high cholesterol, dizziness, abnormal ECG?	☐	☐
c) nervous system—including seizures, headaches, paralysis, fainting, coma, tremors, multiple sclerosis, motor neuron disease (ALS), Parkinson's disease, Alzheimer's, weakness of the muscles, muscular dystrophy or any other neurological disorder?	☐	☐
d) abdominal organs—including ulcer, gallstones, hernia, colitis, jaundice, hepatitis (including hepatitis B carrier), Crohn's disease or other disorder of the stomach, liver, pancreas or intestines?	☐	☐
e) kidneys, bladder, genitals—including sugar, blood, pus or albumin in the urine, stones, venereal disease or any other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
f) blood, glands or lymph glands—including diabetes, anemia, gout, allergies, skin disorders, lupus, thyroid, unusual bleeding or other endocrine disorders?	☐	☐
g) cancer, cysts, tumors, polyps or any other growth or type of malignancy?	☐	☐
h) breast—including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	☐	☐
i) the musculoskeletal system including rheumatism, arthritis, neuritis, fibromyalgia, chronic pain, or any other disease or disorder of the bones, joints or muscles?	☐	☐
j) spine, back, neck—including sprain, strain, pain or disc disease?	☐	☐
k) the ears, eyes, loss of speech, nose, or throat including tinnitus, loss of hearing or blurred vision but excluding myopia or presbyopia?	☐	☐
3.5 Have you ever had or been advised to have treatment or counseling for anxiety, stress, "burnout", depression, fatigue, chronic fatigue, any addiction or any emotional, behavioural, mental or nervous disorder?	☐	☐
3.6 Have you ever been tested (other than for insurance or employment), treated, counseled for or diagnosed with:		
a) Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any other immunological disorders?	☐	☐
b) enlargement of the lymph nodes (glands), chronic diarrhea, unusual skin lesions or unexplained infections?	☐	☐
3.7 This question is to be completed by all female applicants:		
a) Are you currently pregnant? If 'yes', give due date: (mm/yy)	☐	☐
b) Have you ever had a miscarriage, preeclampsia, caesarean section or other complication of pregnancy?	☐	☐
3.8 Have you ever taken drugs for other than medical purposes or been advised to reduce alcohol consumption or received treatment for drug addiction or alcoholism?	☐	☐

3.9 During the past 5 years, have you:

	Yes	No
a) had an electrocardiogram (ECG), blood tests, x-rays or other diagnostic tests?	☐	☐
b) been aware of any symptoms for which you have not yet consulted a health practitioner?	☐	☐
c) consulted a physician or other health practitioner for any physical or mental disorder not mentioned above?	☐	☐
d) been under observation or treatment in any hospital, clinic or other institution or facility?	☐	☐
e) been advised to have any diagnostic test, consultation, hospitalization or surgery, which has not been completed?	☐	☐
3.10 Are you now under observation or taking treatment for any disorder?	☐	☐
3.11 Have you ever had application (or reinstatement) for life, disability, or critical illness insurance rated, modified, declined, postponed, withdrawn or rescinded?	☐	☐
3.12 Have you ever received or claimed benefits or a pension for any sickness, injury or impairment?	☐	☐
3.13 Have you been absent from work for more than a two-week period due to disability within the last two years?	☐	☐

3.14 Details Of 'Yes' Answers To Questions 3.3 – 3.13

Question Number	Reason for Consultation	Onset Date	Last Visit/ Treatment Date	Current Status	Attending Physician or Hospital

4.0 Section 4 – Family History (Biological Family Members)

4.1	#	Age(s) if Living	Age(s) at Death	State of Health **OR** Cause of Death
Father	1			
Mother	1			
Brother(s)				
Sister(s)				

4.2 Have your natural parents, brothers, or sisters had heart disease, kidney disease, diabetes, cancer, stroke, high cholesterol, high blood pressure, polycystic kidney disease, colon polyps, motor neuron disorder, Parkinson's disease, mental disorder, muscular dystrophy, multiple sclerosis, Alzheimer's, Huntington's Chorea or any other hereditary disease?

☐ Yes ☐ No If 'yes', complete following information (if cancer, specify type):

Relationship to Insured	Illness	Age at Onset of Illness	Age of Death (if applicable)

5.0 Section 5 – Non-Medical Information

Provide full details below, if answer is 'Yes', or attach separate sheet (signed & dated)	Yes	No
5.1 Have you ever piloted a plane, ultra-light or glider, or do you intend to do so?	☐	☐
5.2 Have you ever participated in scuba diving, parachuting, hang gliding, motor vehicle or motorboat racing, rodeo activities, mountain climbing or any other hazardous sport (including extreme sports) or avocation, or do you intend to do so?	☐	☐
5.3 Have you ever been charged with impaired diving or had your driver's licence suspended or revoked? If 'yes', provide driver's licence number, licensing province and applicable date(s)	☐	☐
5.4 Have you any intention of travelling or residing outside North America other than for vacations? If 'yes', where, when, why and how long?	☐	☐

Question Number	Details

6.0 Section 6 – Financial/Employment Information – Complete this section **only** if applying for Long Term Disability

6.1 What is your occupation:

6.2 How many years have you worked in this occupation?

6.3 What is your net annual income after regular business expenses, but before taxes, as declared to Canada Customs and Revenue Agency?

Current year expected: $ Prior year: $ 2 years prior: $

6.4 Does your unearned income (income that will continue during a disability, such as investment income) exceed 15% of your total earned income? ☐ Yes ☐ No

If 'yes', provide amount and sources:

6.5 If you are self-employed, complete the following:

a) number of years in your present business

b) number of years in a similar business

c) organization of your business and percentage or ownership

☐ Sole proprietor ☐ Partnership – % ownership ☐ Corporation – % ownership

6.6 Have you ever declared or are you contemplating personal or business bankruptcy? ☐ Yes ☐ No

If 'yes', provide details including date of bankruptcy or date of discharge

7.0 Section 7 – Business Expense Disability Declaration – Complete this section if applying for Business Expense Disability for amount in excess of $1,500 of monthly benefit

7.1 How many persons share the expenses? What is your proportion? %

7.2 Number of employees

State position held by each:

1.	2.	3.
4.	5.	6.

7.3 List the average monthly expenses incurred in the operation of the office:

Expenses	Your Share
a) Rent or property taxes and mortgage interest payments (applicable to business only)	
b) Office maintenance	
c) Public utilities (heat, water, electricity)	
d) Telephone, postage, paging, fax and answering service	
e) Employee salaries and benefits (except as below)	
f) Management company fees (excluding family owned firm)	
g) Accounting services	
h) Professional association membership fees	
i) Property and liability insurance premiums	
j) Leased equipment or scheduled principal payments, interest payments plus depreciation for equipment	
k) Itemize other fixed monthly expenses (normal and customary):	
k-1)	
k-2)	

Do not include expenses incurred for:

- the purpose of acquiring goods for sale, supplies or additions to inventory;
- salaries, fees, drawing account or remuneration for: yourself, any pharmacist, or any person sharing the business expenses of the Member
- travel and/or entertainment

8.0 Section 8 – Agreements and Authorizations

Proposed Insured to read this section, sign and date it.

1. I declare that the above statements are true and complete and form part of any certificate issued.
2. I agree that acceptance of any certificate issued on this application constitutes approval of the provisions of the certifi- cate and ratification of any additions or endorsement or amendments.
3. I agree that any certificate issued on the application takes effect only on delivery to the owner and payment in full of the first premium and then only if there has been no change in my insurability, subsequent to the completion of this application.
4. I authorize the Medical Information Bureau, Inc (MIB Inc.) to disclose to Desjardins Financial Security and/or Manulife Financial or its/their Reinsurers any personal information or personal health information.
5. I have read and received the Pre-Notice form describing the procedures of the MIB Inc. and the Confidentiality Agreement.
6. I understand that a consumer report, to obtain personal or credit information, may be used in connection with this application for underwriting life and disability insurance by the underwriting staff of Desjardins Financial Security and/or Manulife Financial and authorize completion of such a report if necessary. This authorization is valid only during the initial underwriting and the contestability period.
7. I authorize Desjardins Financial Security and/or Manulife Financial to perform tests, examinations [such as, but not limited to, test for Human Immunodeficiency Virus (HIV), blood profiles and electrocardiogram], as may be required to underwrite this application for insurance. On my written request, the Medical Director of Desjardins Financial Security and/or Manulife Financial will disclose all medically related information obtained during the underwriting process to my personal physician.
8. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility that I have attended, or any insurance company, MIB Inc., government agency, provincial health care insurer or other organi- zation, institution or person that has any personal information or personal health information relating to me to disclose particulars to Desjardins Financial Security and/or Manulife Financial, its/their Reinsurers, its/their agents, as required, for the purpose of underwriting my application for life or disability insurance, or for administering any claim, including extended health insurance.
9. As necessary, for underwriting life or disability insurance, or for administering any claim including extended health insurance, I authorize Desjardins Financial Security and/or Manulife Financial to
   a. exchange my personal information with each other;
   b. disclose my personal information or personal health information with its/their agents, affiliates, Reinsurers and the
   b) Ontario Pharmacists' Association;
   c) use my personal information or personal health information in any other files which it/they currently hold(s)
   d) respecting me, or which may be opened in the future; and/or
   e) use any existing files, opened or closed, that it/they currently hold(s) respecting me
   f) I acknowledge that further information concerning the collection, use and disclosure of personal information by OPA, Manulife Financial and Desjardins Financial is available through their individual websites listed below, or by request: OPA: www.opatoday.com (search word "Privacy Policy")
   g) Manulife Financial: www.manulife.ca (search word "Privacy Policy") Desjardins Financial: www.dfs.ca (search word "Privacy Policy")

A photographic copy of these signed authorizations is as valid as the original.

Insurance is a contract based on trust. Failure to fully disclose facts material to this application can render the contract void.

Date	Signature of Proposed Insured	Date	Signature of Owner (if other than applicant)
Date	Signature of Witness	Date	Agent's signature

Hospitals and doctors may require an original authorization to disclose personal health information. Please sign and date the authorization below to avoid any delays in our request for the necessary medical reports.

Authorization to Obtain Personal Health Information: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, program administrator, the Medical Information Bureau, Inc., the Ontario Pharmacists' Association, consumer reporting agency, or other organization, institution or person that has any record of me or my health, to disclose my personal information or my personal health information as required by Desjardins Financial Security and/or Manulife Financial to process or administer my application and/or my claims.

Signature of Proposed Insured	Date
Signature of Witness/Agent	Date

9.0 Section 9 – Detach and retain for your records

Pre-Notice regarding the Medical Information Bureau, Inc. (MIB)
Personal information or personal health information obtained will be treated as confidential. Desjardins Financial Security and/or Manulife Financial or its/their Reinsurers may, however, make a brief report thereon to the MIB, a non-profit membership organization of the insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or make a claim for benefits to such a company, MIB, upon request, will disclose to such company with the personal information or personal health information on file.

Upon receipt of a request from you, MIB will arrange disclosure of any personal information or personal health information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction. The address of MIB office is:

Medical Information Bureau, Inc.
330 University Avenue, Suite 501,
Toronto, ON M5G 1R7

The telephone number is (416) 597-0590.

Release of Information
Desjardins Financial Security and/or Manulife Financial may also disclose, with my authorization to do so, personal information or personal health information, as required, in its/their file(s) to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Confidentiality Agreement
In order to ensure the confidentiality of the personal information or personal health information held concerning you, Desjardins Financial Security and/or Manulife Financial will establish an insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claim. Only employees or authorized organizations who will be responsible for underwriting, administration, investigations and claims, or any other person whom you authorize, will have access to this file. Your file will be kept in the Desjardins Financial Security and/or Manulife Financial office(s). You are entitled to consult personal information or personal health information contained in this file and, if applicable, to have it rectified by submitting a written request to the following address:

The Manufacturers Life Insurance Company
Affinity Markets, Manulife Financial
2 Queen Street East PO Box 4213 Stn A
Toronto, Ontario M5W 5M3

or

Desjardins Financial Security
Group Medical Underwriting Department
C.P. 3000
200, rue des Commandeurs
Lévis, QC
G6V 9X8

10.0 Section 10 – Where to send application

Please mail application to:

ONTARIO PHARMACISTS ASSOCIATION
Advocating Excellence in Practice and Care

Ontario Pharmacists Association
Insurance Department
155 University Avenue, Suite 600
Toronto, Ontario M5H 3B7