Voluntary Dental Care, and/or Extended Health Care (with Optional Hospital)

Ontario Nurses' Association Benefit Program – APPLICATION

Part 1 – Member Information

PLEASE PRINT

First Name and Middle Initial(s) | Last Name | Date of Birth (d/m/y) | Place of Birth | ☐ M ☐ F

Address — Street/Apt. No. | City/Town | Province/Territory | Postal Code

Current Occupation | Employer Name | Date of Hire (d/m/y) | ONA Member No. | Date of ONA Membership (d/m/y)

Telephone Number: Home: ______________ Work: ______________ Ext.: ________

Provincial Health No. | Home E-mail Address | Work E-mail Address

Part 2 – Employment Status and Eligibility

Please complete one of these sections, based on your current status.

Active	*Retiring/Retired*
☐ Full-time ☐ Part-time Are you Actively at Work? ☐ Yes ☐ No If Yes, please review the Open Enrollment Eligibility guidelines outlined below to determine if you qualify. If No, you will be eligible to apply upon your return to an Actively at Work status.	Employer Name Before Retiring Last Date Actively at Work Before Retiring (d/m/y) Date Coverage Ended/Will End (d/m/y) Previous Plan: ☐ Employer's plan ☐ Spouse's plan **Please refer to the Open Enrollment guidelines below.**

IMPORTANT:

Open Enrollment Eligibility: If you qualify for Open Enrollment, you can apply for Extended Health Care and Optional Hospital coverage without completing the Medical Evidence Questionnaire – Health Declaration (Part 5). To qualify, you must be Actively at Work and your application must be received by your Plan Administrator, Johnson Inc. within 60 days of:

☐ the first day you became a new ONA Member;
☐ the day you lost coverage due to a change from full-time to part-time status;
☐ the day coverage terminated under your spouse's employer benefit program (or any other group plan); or
☐ the day you retired (subject to having been actively at work on the day prior to your retirement).

Note:

- Retired Members can enroll without providing medical evidence within 60 days of losing retiree or spousal coverage;
- Loss of coverage must have been through no fault of your own;
- The level of replacement coverage cannot exceed that which was lost; and
- The provincial government health plan coverage is required to be eligible for Extended Health Care coverage.

Do you qualify for the 60-Day Open Enrollment?

☐ **YES —** If losing/lost coverage, please include a letter from your (spouse's) employer confirming the specific benefit(s) lost, the date and reason for loss of coverage(s).

☐ **NO —** You must complete the Medical Evidence Questionnaire (Part 5). Coverage will be subject to underwriting review and may be approved or declined.

If YES, you do not need to complete Part 5 of this Application Form. Simply sign and date the Application Form in Part 6 and send it to your Plan Administrator, Johnson Inc..

If NO, you are considered a late applicant and must complete Part 5 – Medical Evidence Questionnaire – Health Declaration below, when applying for Extended Health Care (EHC) coverage. If you apply for Dental Care, coverage is limited to $200 per person for the first 12 months of coverage.

Part 3 – Selecting Your Coverage

Select your coverage by checking the appropriate box for each benefit. Optional Hospital is available **only if** you have selected EHC.

Level of Coverage	Dental Care	Extended Health Care	Optional Hospital
Single (1 participant)	☐	☐	☐
Couple (1 participant + 1 dependant)	☐	☐	
Family (1 participant + 2 or more dependants)	☐	☐	

Part 4 – Dependant Information (complete if applying for Spouse or Dependent Child(ren)'s Coverage)

Spouse's Information

First Name and Middle Initial(s)	Last Name	Provincial Health No.	Date of Birth (d/m/y)	M	F
				☐	☐

Dependent Child(ren)'s Information

If the dependent child is between the ages of 18 and 25 and is in full-time attendance at an accredited college, university or other institute of higher learning, please include a confirmation letter from the registrar.

	First Name and Middle Initial(s)	Last Name	Provincial Health No.	Date of Birth (d/m/y)	M	F
1.					☐	☐
2.					☐	☐
3.					☐	☐

Please provide any additional dependant information on a separate, **signed and dated attachment.**

Part 5 – Medical Evidence Questionnaire – Health Declaration (to be completed by late applicants ONLY)

Complete this section only if you are applying for Extended Health Care and Optional Hospital coverage after the 60-Day Open Enrollment Period.

Have you ever:	**Member**		**Spouse** (If applicable)		**Children** (If applicable)	
1. Consulted, been treated for, or advised by a physician that you have any disease or disorder of the:	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
a) Heart or Circulatory System?	☐	☐	☐	☐	☐	☐
b) Lungs or Respiratory System?	☐	☐	☐	☐	☐	☐
c) Stomach, Liver, or Gastrointestinal System?	☐	☐	☐	☐	☐	☐
d) Kidney, Pancreas, or Thyroid?	☐	☐	☐	☐	☐	☐

	Member Yes	Member No	Spouse (If applicable) Yes	Spouse (If applicable) No	Children (If applicable) Yes	Children (If applicable) No
e) Endocrine or Glandular System?	☐	☐	☐	☐	☐	☐
f) Neck, Back, Bones, Joints, Knees, Hips, Tendons, or Muscles?	☐	☐	☐	☐	☐	☐
g) Brain or Neurological System?	☐	☐	☐	☐	☐	☐
h) Immune System?	☐	☐	☐	☐	☐	☐
i) Blood or Blood Vessels?	☐	☐	☐	☐	☐	☐
j) Breast, Prostate, Reproductive, or Genitourinary System?	☐	☐	☐	☐	☐	☐
k) Eyes, Ears, Nose, Throat, or Skin?	☐	☐	☐	☐	☐	☐
2. Had any consultations with a specialist or been hospitalized or institutionalized during the past 5 years, or have you been recommended to have any investigations or undergo any treatment or surgery which was not done or is planned?	☐	☐	☐	☐	☐	☐
3. Had or been treated for:	☐	☐	☐	☐	☐	☐
a) High Blood Pressure?	☐	☐	☐	☐	☐	☐
b) Psychiatric Illness, Stress, Anxiety, Depression, Chronic Fatigue, Fibromyalgia, Nervous, Emotional, or Behavioural Disorder?	☐	☐	☐	☐	☐	☐
c) Diabetes?	☐	☐	☐	☐	☐	☐
d) Chronic infections including Hepatitis Carrier State or HIV Infection?	☐	☐	☐	☐	☐	☐
e) Cancer or Tumour?	☐	☐	☐	☐	☐	☐
f) Stroke or Transient Ischemic Attack (TIA)?	☐	☐	☐	☐	☐	☐
g) Elevated Cholesterol or Blood Lipids?	☐	☐	☐	☐	☐	☐
h) Arthritis, Osteoporosis, Osteopenia, Paralysis, Weakness or Chronic Pain?	☐	☐	☐	☐	☐	☐
4. Consulted a medical practitioner and received treatment or been diagnosed with a disease or disorder, other than already indicated above?	☐	☐	☐	☐	☐	☐
5. Applied for insurance which was either not granted, or issued with ratings or exclusions, or have you ever made a claim or received a pension for sickness, accident or injury?	☐	☐	☐	☐	☐	☐
6. In the past 10 years, used drugs for other than medical purposes, used marijuana, or been treated for or advised to reduce alcohol or drug use?	☐	☐	☐	☐	☐	☐

In the space below, please provide full details for every "yes" answer given above. If required, additional information can be provided on a separate page. **Please sign and date your attachments.**

Question Number	Person to Whom it Applies	Reason for Consultation	Date of First Visit/ Treatment	Date of Last Visit/ Treatment	Result of Last Consult/ Current Status	Name/ Address of Physicians/ Hospital

7. Are you, your spouse or any dependent children applying for coverage, currently using or expected to use in the next 3 months any drug, medication or serum, or other treatment? If yes, provide details in the space below:

Proposed Insured	Name of Drug/Medication/ Serum Treatment	Condition Being Treated	Strength and Daily Dose of the Drug/ Medication/Serum	Monthly Cost	Length of Time on this Drug/ Medication/Serum

The insurer may request a medical examination, urinalysis or tests such as a general blood profile, including blood test for HIV which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law.

---------------------------CAREFULLY DETACH THIS PORTION AND RETAIN FOR YOUR RECORDS---------------------------

Notice on Exchange of Information: All information requested will be for insurance purposes only and will be treated as confidential. The insurer or its reinsurers may, however, make a brief report on it to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies which operates an insurance information exchange on behalf of its members. Subject to your authorization, the bureau will supply information from its files to another member insurance company to which you have applied for life or health insurance or to which a claim is submitted. On your request, the bureau will arrange for disclosure to you of any information it may have in your file on you, your spouse or your children being insured under this plan. If you question the accuracy of the bureau's file, you may contact the bureau to seek a correction. The address of the bureau's information office is: 330 University Avenue, Toronto, ON M5G 1R7 (telephone 416-597-0590).

8. a) Are you currently pregnant? ☐ Yes ☐ No ______________________ ☐ Member ☐ Spouse
(If applicable) Due Date (d/m/y)
b) Have you ever experienced any complications with this or any past pregnancies? ☐ Yes ☐ No

9. Member: Height: _________ Weight: _________ Spouse (If applicable): Height: _________ Weight: ________

10. Have you experienced any weight change in the past 12 months?
Member: ☐ Yes ☐ No If yes, Loss: _________ lbs. Gain: _________ lbs. Reason: ______________________
Spouse: ☐ Yes ☐ No If yes, Loss: _________ lbs. Gain: _________ lbs. Reason: ______________________

11. Family Physician(s) – Please provide the following information:

	Physician's Name	Address	Telephone Number	Date Last Consulted (d/m/y)	Reason/Diagnosis/ Treatment/Results
Member					
Spouse					
Children					

If required, additional information can be provided on a separate page. **Please sign and date your attachments.**

Part 6 – Agreements and Authorizations

All applicants are required to read, sign, and date this section and mail the application to Johnson Inc., along with your cheque marked "VOID". Remember to detach and retain the bottom part of this section for your records. Please ensure that all applicable sections are completed, or the application will be returned to you.

DECLARATION: I (the Member/Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife Financial). I/we declare that the statements contained in this application, including but not limited to the Health Declaration, are true and complete and together with any other forms signed by me/us in connection with this application, forms the basis for any certificate issued hereunder. I/we understand that any material misrepresentation, including misstatement of smoker status, shall render the insurance voidable at the instance of the insurer. I/we understand that there are exclusions and limitations on the coverage applied for. I/we understand that insurance will take effect on the first of the month following receipt of my/our properly completed application (including the Health Declaration) and payment of the first premium, subject to approval of the insurer's underwriters. I understand that any health information must be accurate as at the date the application is signed.

AUTHORIZATION AND REVOCATION: Relative to the insurance applied for, I/we the undersigned person(s) to be insured, or parent/guardian if the person to be insured is a minor child, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the Medical Information Bureau, the plan administrator, the insurance plan sponsor, any investigative and security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me/us or my/our health or the health of any member of my/our family to be insured under this plan to provide to Manulife Financial, the Plan Administrator or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I/we authorize Manulife Financial to consult its existing files for this purpose. I/we authorize Johnson Inc., its subsidiaries, affiliates and agents to use the information in this application and its existing files to offer me/us their products or services. I/we understand that my/our consent to the use of such information to offer me/us products or services is optional and that if I/we wish to discontinue such use I/we may write to Johnson Inc. at 1595 – 16th Avenue, Suite 700, Richmond Hill, ON L4B 3S5. A photocopy or faxed copy of this authorization shall be as valid as the original.

I/we declare that I/we have been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent. This consent shall take effect on the date of signing of this application and shall expire 7 years after the termination date of any certificate issued as a result of this application. I/we understand that this consent may be revoked at any time and that if as a result of such revocation the insurer is unable to obtain proof of claim, this may result in claims not being paid.

I/we acknowledge receipt of the NOTICE ON EXCHANGE OF INFORMATION and the NOTICE ON PRIVACY AND CONFIDENTIALITY.

PAYMENT AUTHORIZATION: I authorize monthly deductions from my bank/trust/credit union account. Due to application processing time, and the effective date of coverage, the initial deduction may cover up to 3 months of premium. If more than one signature is required on cheques issued from a joint account, all depositors must sign below.

I have attached a cheque marked "VOID" ☐ Yes

If you are applying for more than one coverage, only one "VOID" cheque is required.

____
Signature of Member Date (d/m/y)

____
Signature of Spouse Date (d/m/y)
(If applying for coverage)

____
Signature of Joint Account Depositor Date (d/m/y)
(If applicable)

———CAREFULLY DETACH THIS PORTION AND RETAIN FOR YOUR RECORDS———

Notice on Privacy and Confidentiality: The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial and Johnson Inc. will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial and Johnson Inc. employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. Your file is secured in our offices. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3. Coverage underwritten by The Manufacturers Life Insurance Company (Manulife Financial).

For more information contact Johnson Inc., the ONA Plan Administrator, at:

Local callers: 905-764-4959
Toll-free: 1-800-461-4155
Fax number: 905-764-4163
Website: www.johnson.ca

1595 – 16th Avenue
Suite 700
Richmond Hill, ON
L4B 3S5