Voluntary Life, Accidental Death and Dismemberment and/or Long Term Disability Insurance

Ontario Nurses' Association Benefit Program – APPLICATION

Part 1 – Member Information (Complete this section even if applying for Spousal Coverage only)

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 ____

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

Telephone Number: Home: ____ Work: ____ Ext.: ____

Current Occupation ____ | Home E-mail Address ____ | Work E-mail Address ____

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Retired

Do you currently have Long Term Disability (LTD) coverage from other sources? ☐ Yes ☐ No

If Yes, LTD coverage from other sources must be taken into consideration when you select your amount of coverage. Your combined coverage should not exceed 60% of your last year's average gross monthly earned income. In the event of a claim, your benefit amount may be reduced by other sources of income. Please indicate below any other LTD coverage you currently have:

Name of Insurer: ____ Amount of Coverage: ____

NOTE: Current LTD coverage must be taken into consideration when selecting your LTD coverage below.

Part 2 – Selecting Your Coverage

A. *Long Term Disability* Insurance (LTD) — *Available to ONA Members ONLY*

Members without employer-sponsored LTD coverage are covered (through Member Dues) for a Basic Monthly Benefit of $250. Choose the Voluntary Monthly Benefit amount that would meet your financial needs.

Are You Actively at Work? ☐ Yes ☐ No If No, you will be eligible to apply for LTD upon your return to an Actively at Work status.

Select Your LTD Coverage*:

Available in units of $250 (minimum coverage - $250).

Member:	☐ $250	☐ $750	☐ $1,250	☐ $1,750	☐ $2,250	☐ $2,750	☐ $3,250
	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000	☐ $2,500	☐ $3,000	

*Note: The maximum amount of monthly coverage available is 60% of last year's T4 income, to a maximum benefit level of $3,500 including your $250 Base Plan coverage. Please refer to the calculation tool in the LTD brochure.

IMPORTANT:

Open Enrollment Eligibility: If you qualify for Open Enrollment, you can apply for LTD without completing the Medical Evidence Questionnaire – Health Declaration (Part 3). To qualify, you must be Actively at Work and your application must be received by your Plan Administrator, Johnson Inc., within 30 days of:

☐ the first day you became a new ONA Member; or

☐ the day you lost coverage due to a change from full-time to part-time status.

Note:

- Loss of coverage must have been through no fault of your own; and
- The level of replacement coverage cannot exceed that which was lost.

Do you qualify for the 30-Day Open Enrollment?

Date coverage ended/ will end ________________________ (d/m/y)
(If applicable)

☐ **YES** — If losing/lost coverage, please include a letter from your 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 3). LTD coverage will be subject to underwriting review and may be approved with exclusions or declined.

B. *Life* Insurance and *Accidental Death and Dismemberment* Insurance (Available to Member and Spouse) – Life Insurance coverage is subject to underwriting review and approval, and may be declined. Applicants must complete the questionnaire (Part 3).

Select Your Life Insurance Coverage:

Available in units of $25,000 (minimum coverage: $50,000). Note: 10% premium reduction applies to coverage amounts of $150,000 or greater.

Member:	☐ $50,000	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000
	☐ $75,000	☐ $125,000	☐ $175,000	☐ $225,000	
Spouse:	☐ $50,000	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000
	☐ $75,000	☐ $125,000	☐ $175,000	☐ $225,000	

Select Your Accidental Death and Dismemberment Insurance (AD&D) Coverage:

Available in units of $50,000 (minimum coverage - $100,000).

Member:	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000
Spouse:	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000

Spousal Information (complete if applying for Spousal Life or AD&D Insurance coverage)

________________________ | ________________________ | ________________ | ______________ ☐ M ☐ F

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

Beneficiary Designation(s) (Applies to Life and AD&D only)

Beneficiary – Member's Coverage ________________________ | ________________________ | ______________ ☐ Life ☐ AD&D

Beneficiary's First Name | Last Name | Relationship

If beneficiary is a minor, name of Trustee: ____

Beneficiary – Spouse's Coverage ________________________ | ________________________ | ______________ ☐ Life ☐ AD&D

Beneficiary's First Name | Last Name | Relationship

If beneficiary is a minor, name of Trustee: ____

Part 3 – Medical Evidence Questionnaire – Health Declaration

The questionnaire must be completed by all Life Insurance applicants, and LTD Late Applicants.

Have you ever:	**Member**		**Spouse** (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**
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
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. Used tobacco products in the last 12 months or do you intend to smoke in the future?	☐	☐	☐	☐
7. 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

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.

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: __________

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).

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					

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

Part 4 – 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. Suicide within two years of the effective date is a risk not covered under the Voluntary Life Plan. 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)

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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