ONTARIO NURSES' ASSOCIATION

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

Ontario Nurses' Association Benefit Program – APPLICATION

Part 1 – Member Information

PLEASE PRINT

First Name and Middle Initial(s) | Last Name | Date of Birth (DD/MM/YYYY) | Place of Birth | ☐ M ☐ F

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

Employer Name | Date of Hire (DD/MM/YYYY)

Work Telephone No. | Ext. | ONA Member No. | Date of ONA Membership (DD/MM/YYYY)

Home Telephone No. | Home E-mail Address | Work E-mail Address

Do you have a valid Provincial Health Card: ☐ Yes ☐ No

Part 2 – Employment Status and Eligibility

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

Active

Are you Actively at Work?

☐ Yes ☐ Full-time ☐ Part-time

☐ 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.

Retiring/Retired

Employer Name Before Retiring

Last Date Actively at Work Before Retiring (DD/MM/YYYY)

Date Coverage Ended/Will End (DD/MM/YYYY)

Previous Plan: ☐ Employer's plan ☐ Spouse's plan

Please refer to the Open Enrollment guidelines below.

Open Enrollment Eligibility:

If you qualify for Open Enrollment, you can apply for Extended Health Care and Optional Hospital coverage without completing the Health Declaration (Part 6). 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 at the time of enrollment 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;
- The provincial government health plan coverage is required to be eligible for Extended Health Care coverage;
- Additional medical information may be required to underwrite your application. If you require more space to complete any part of this application, please attach a separate sheet, signed and dated;
- All applicants must complete and sign the Applicant's Authorization and Declaration.

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 with amount, the date and reason for loss of coverage(s).

If YES, you do not need to complete Part 6 of this Application Form. Simply sign and date the Application Form in Part 8 and send it to Johnson Inc.

☐ **NO —** You must complete the Medical Declaration (Part 6). Coverage will be subject to underwriting review and may be approved or declined.

If NO, you must complete Part 6 – Medical Declaration on next page, when applying for Extended Health Care (EHC) 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 – Information Of Individuals To Be Covered

Name	Male/ Female	Birth Date	Age	Smoker? No. of cigarettes/day	Height inch/cm	Weight lbs/kg	Weight gain/ loss in last year	Reason for weight change
APPLICANT		DD/MM/YYYY						
SPOUSE		DD/MM/YYYY						
DEPENDANT		DD/MM/YYYY						
DEPENDANT		DD/MM/YYYY						
DEPENDANT		DD/MM/YYYY						

Part 5 – Treating Qualified Health Care Practitioner

Primary Health Care Provider (PHCP)*	For Applicant	For Spouse	For Dependant(s)
Name of PHCP			
Address of PHCP			
Telephone # of PHCP			
Date of last consultation			
Reason for last consultation			
Diagnosis made			
Treatment given			

*The Qualified Health Care Practitioner who holds the majority of your medical records.

Name and Telephone Number of any other Qualified Health Care Practitioners consulted (if none, print "none"):

_____

_____

Date and Reason for Last Consultation: _____

_____

To which individual applying for coverage does this apply? _____

Part 6 – Medical Declaration (For applicants who do not qualify for the 60-Day Open Enrollment)

	Applicant	Spouse	Dependant
1. Have you, your spouse or any listed dependant(s) ever consulted a Physician or Qualified Health Care Practitioner about, been treated for or had any known indication of:			
a) High Blood Pressure, High Cholesterol or any Circulatory or Blood Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Heart or Blood Vessel Disorder, Heart Murmur, Chest Pain, Angina, Stroke or Transient Ischemic Attack (TIA)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Back, Neck, Disc, Hip or Knee Pain or Disorder, Fibromyalgia, Osteoporosis, Osteopenia, Chronic Pain, Paralysis, Weakness or Numbness, or any other Musculoskeletal Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Digestive System Disorder, Crohn's Disease, Ulcerative Colitis, Liver Disease or Disorder including Hepatitis or Hepatitis Carrier State	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Mental, Nervous, Emotional or Neurological Disorder including Depression, Anxiety, Attention Deficit Disorder or Stress	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Alcohol or Drug Abuse, or any Addiction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Allergies, Asthma, Bronchitis, Respiratory Disorder, Shortness of Breath or Sleep Apnea	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Arthritis, Rheumatism or Rheumatoid Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Cancer, Tumour, Cyst, Polyp or any Growth	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Skin Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Breast Disorder, Menopause, Reproductive Disorder, Infertility or Assisted Conception	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Bladder, Kidney or Prostate Disorder or other Genitourinary Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Headaches or Migraines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) Diabetes, Endocrine Disorder, Pituitary or Thyroid Disorder or Lupus	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) Eye or Ear Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) Any other Complaint, Condition, Disease or Disorder Please specify_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you, your spouse or any listed dependant(s) ever been treated for, hospitalized or had any known Physical Impairments, Congenital Abnormality, Medical Condition, Injury, Disease or Disorder not stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you, your spouse or any listed dependant(s) ever been advised to have an investigation, hospitalization or surgery which has not been completed, or are awaiting any tests or test results?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you, your spouse or any listed dependant(s) ever been on disability or been unable to perform normal daily activities for a minimum of 2 weeks within the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5. If any "Yes" answers to questions 1 to 4 above, please give explanation below:

Question Number	Name of individual with condition	Illness/ condition/ diagnosis	Date diagnosed	Duration	Name and address of Qualified Health Care Practitioner and/or hospital providing treatment	Current status of condition
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			

6. Are you, your spouse or any listed dependant(s) currently using or expecting to use in the next 3 months or have you discontinued use in the last 3 months any drug, medication, serum or other treatment? If "Yes", provide details below:

Name of Individual	Name of the drug/ medication/serum/ treatment	Condition being treated	Strength and daily dosage of the drug/medication/ serum	Length of time on this drug/medication/serum/ treatment

7. Are you, your spouse or any listed dependant(s) pregnant? If "Yes",

Name of pregnant individual _____ Due Date_____

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

Notice on Exchange of Information: Information about MIB, Inc. 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, Inc. 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, Inc. 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, Inc. will share any information it has on file. You may review the information in your file, and request a correction if necessary, by contacting MIB, Inc. at: MIB, Inc., 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7 Telephone: (416) 597-0590 Fax: (416) 597-1193 Email: canada_disclosure@mib.com

Part 7 – Your Payment Method

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. Please complete and submit a Pre-Authorized Debit Plan Agreement Form. Your application will not be processed without the completion of this form.

Payment Authorization – For Pre-Authorized Debit (PAD) payment options

I/We authorize Johnson Inc. to withdraw for monthly insurance premiums. I/We understand that except for the initial premium, which is due with this application, subsequent premiums will be withdrawn on the 5th day of the month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts, as they may change in accordance with the insurance contract and as required to administer the policy; **I/we waive the right to receive 10 days' notice of the amount and date of each automatic withdrawal from my/our account.** If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Johnson Inc. may attempt to withdraw that payment again within 30 days. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. Premium amounts may change in accordance with my/our insurance contract. I/We and/or Manulife can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Johnson Inc. receives another form of payment. Any refund of premium paid pursuant to this authorization shall be made to the policy owner.

If you have any questions about withdrawals from your bank account, contact Johnson Inc. at 1-800-461-4155, fax 1-866-623-8257, ona@johnson.ca or write to Johnson Inc., PO Box 4216, Station A, Toronto, ON, M5W 5M7. ona.johnson.ca You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, you may contact your financial institution or visit www.payments.ca.

PAYMENT AUTHORIZATION: I authorize monthly deductions from my bank/trust/credit union account. I acknowledge premium deductions are taken one month in advance. 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/we have attached a signed PAD form along with a cheque marked "VOID".

_____ | DD/MM/YYYY
Signature of Account Holder Date

_____ | DD/MM/YYYY
Second Signature If Joint Account Date

Part 8 – Personal Information Statement

In this Statement, "you" and "your" refer to the policyowner or holder of rights under the contract, the insured providing consent. "We", "us", "our" and "the Company" refer to The Manufacturers Life Insurance Company and our affiliated companies and subsidiaries.

Updates to this Statement and further information about our privacy practices are posted to www.manulife.ca.

We collect, use, verify and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By selecting submit or by signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this Personal Information Statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- Identifying information such as your name, address, telephone number(s), email address, your date of birth, or driver's license
- Medical information that any organization or person has about you
- Any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test.
- Your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- A copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- A personal investigation, financial information, credit bureau report and/or a consumer report from other organizations, person or source that has any information or records about you
- Information about how you use our products and services, and information about your preferences, demographics, and interests
- Other personal information we may require to administer our business relationship with you

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

- Your completed applications and forms
- Other interactions between you and the Company
  - Other sources, such as:
  - Your advisor or authorized representative(s)
  - Third parties with whom we deal in issuing and administering your policy now, and in the future
  - Public sources, such as government agencies and internet sites

What do we use your personal information for?

We will use your personal information to:

- Help us properly administer the products and services that we provide and to manage our relationship with you
- Confirm your identity and the accuracy of the information you provide
- Evaluate your application, and issue and administer the rights under the policy
- Comply with legal and regulatory requirements
- Understand more about you and how you like to do business with us
- Analyze data to help us understand our customers better so we can improve the products and services we provide
- Determine your eligibility for, and provide you with details of, other products or services that may be of interest to you

Who do we disclose your information to?

- Persons, financial institutions and other parties with whom we deal in issuing and administering your policy now, and in the future
- Authorized employees, agents and representatives
- Any person or organization to whom you gave consent
- People who are legally authorized to view your personal information
- Service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical and investigative agencies)
- Your medical doctor
- Public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease

The abovementioned people, organizations and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:

- will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- will be shared with all the owners and any subsequent owners of those contracts and all people to be insured

How long do we keep your information?

The longer of:

- the time period required by law and by guidelines set for the financial services industry, and
- the time period required to administer the products and services we provide.

Withdrawing your consent

You may withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the contract or we may treat your withdrawal of consent as a request to terminate the contract.

If you wish to withdraw your consent, phone our customer care center at 1-888-MANULIFE (626-8543), or 1-888-MANUVIE (626-8843) in Quebec, or write to the Privacy Officer at the address below.

Accuracy and Access

You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question or a concern, wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer Manulife: P.O. Box 1602 500 King Street N Waterloo, ON N2J 4C6

Privacy_office_canadian_division@manulife.com

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

Part 9 – Declaration and Authorization

I/We (the Member/Spouse) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). I declare that the statements contained in this application, are true and complete and, together with any other forms signed by me in connection with this application, form the basis for any coverage issued hereunder. I understand that any material misrepresentation including misstatement of smoker status shall render the insurance voidable at the instance of the insurer, and that suicide within two years of the effective date is a risk not covered. I understand that there are exclusions and limitations on the coverage applied for.

Relative to the insurance applied for, I, the undersigned person to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic, or other medically related facility, insurance company, the MIB Inc., the group policy 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 or my health to provide to Manulife or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Manulife to consult its existing files for this purpose. I authorize Manulife to hold a personal file about myself and my insurance coverage. I authorize Manulife, the plan administrator, and their authorized staff, agents, representatives, advisors, and service providers to use and exchange information needed for underwriting, financial management, administration, and adjudication of claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers. A photocopy or faxed copy of this authorization shall be as valid as the original.

I declare that I 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. I 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 understand that in connection with this application, Manulife may request a medical examination, urinalysis, or tests such as a general blood profile (including blood test for HIV) which will be conducted at no expense to the applicant, and that any positive infectious disease results will be reported to the appropriate health department if required by law.

I/We hereby designate the individual(s) named as beneficiary to receive the proceeds in accordance with any certificate issued hereunder.

I/We acknowledge my/our receipt of and agreement with the Personal Information Statement and Notice of Exchange on Information.

If my/our application is approved, I/we will receive a certificate specifying the coverage provided and the main certificate provisions.

Signature of Member	DD/MM/YYYY Date	Signature of Spouse (If applying for coverage)	DD/MM/YYYY Date

For more information contact Johnson Inc.

Toll-free: 1-800-461-4155
Fax number: 1-866-623-8257
Website: ona.johnson.ca

PLEASE MAIL YOUR APPLICATION TO:

Johnson Inc. PO Box 4216, Station A, Toronto, ON, M5W 5M7

JOHNSON INSURANCE Manulife ONTARIO NURSES' ASSOCIATION