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	Retiring/Retired
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.	Employer Name Before Retiring DD/MM/YYYY Last Date Actively at Work Before Retiring DD/MM/YYYY Date Coverage Ended/Will End 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. 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 – 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)

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:	Applicant	Spouse	Dependant
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

	Applicant	Spouse	Dependant
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.**

CAREFULLY DETACH THIS PORTION AND RETAIN FOR YOUR RECORDS

Notice on Exchange of Information: Information regarding your insurability will be treated as confidential. The Insurer or its reinsurers may, however, make a brief report on it to MIB, Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies which operates an insurance information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416 597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction. The address of MIB's information office is: 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. The insurer, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.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., 1596 – 16th Avenue, Suite 700, Richmond Hill, ON L4B 3S5. 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".

Signature of Account Holder	Date (DD/MM/YYYY)	Second Signature If Joint Account	Date (DD/MM/YYYY)

Part 8 – Declaration and Authorization

DECLARATION: I (the Member/Applicant) hereby apply for insurance to The Manufacturers Life Insurance Company (Manulife). 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 form 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 other exclusions and limitations will apply to the coverage applied for. 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. If my/our application is approved, I/we will receive a certificate specifying the coverage provided and the main certificate provisions.

AUTHORIZATION: I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, MIB, Inc., any insurance company, agent, broker, market intermediary, plan sponsor, group policy administrator or third-party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me or my health, or the health of any member of my family to be insured under this plan, to provide such information to Manulife or its reinsurers for the purpose of this application, any certificate issued hereunder and any subsequent claim. I further authorize Manulife to consult this application and its existing files for this purpose. 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 acknowledge receipt of and agreement with the Notice on Privacy and Confidentiality. A photocopy of this signed authorization shall be as valid as the original.

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

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

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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 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, relative to the insurance applied for. Access to this file will be restricted to those Manulife 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. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. 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, Manulife, P.O. Box 1602, Del. Stn 500-4-A, Waterloo, ON, N2J 4C6.