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 (DD/MM/YYYY) | Place of Birth | ☐ Smoker* ☐ Non-smoker** ☐ M ☐ F

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

Employer Name | Date of Hire (DD/MM/YYYY) | ONA Member No. | Date of ONA Membership (DD/MM/YYYY)

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

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

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

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

Please refer to the Open Enrollment Eligibility section below.

Part 2 – Other Insurance

Your combined coverage must not exceed 67% 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.

Do Member and spouse have any pending or existing life or disability insurance coverage with Manulife or any other company? ☐ Yes ☐ No
If yes, complete the following:

Company Name	Type of insurance	Personal or Business	Coverage Amount	Waiting Period	Benefit Period	Taxable?	Will this coverage be replaced?
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive your new insurance contract. A replacement form or declaration may be required, and we may not be able to issue an insurance contract where replacement is indicated.

Applicant Occupation | Applicant Annual Earned Income (income after expenses and before taxes) | Applicant Net Worth (assets minus liabilities)

Spouse Occupation | Spouse Annual Earned Income (income after expenses and before taxes) | Spouse Net Worth (assets minus liabilities)

Part 3 – 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 Base Plan monthly benefit of $250. Choose the additional 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†:

Coverage Amount: ☐ $250 ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,250 ☐ $1,500 ☐ $1,750 ☐ $2,000 ☐ $2,250 ☐ $2,500 ☐ $2,750 ☐ $3,000 ☐ $3,250 ☐ $3,500 ☐ $3,750 ☐ $4,000 ☐ $4,250 ☐ $4,500 ☐ $4,750

†**Note:** The maximum amount of monthly coverage available is 67% of last year's T4 income, to a maximum benefit level of $5,000 including your $250 Base Plan coverage. Please refer to the calculation tool in the rate sheet.

Open Enrollment Eligibilty:
If you qualify for Open Enrollment, you can apply for LTD without completing Parts 4 and 5. To qualify, you must be Actively at Work and your application must be received by Johnson Inc., within 60 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 60-Day Open Enrollment?

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

Date coverage ended/will end (If applicable) _____ (DD/MM/YYYY)

☐ **NO** — You must complete Parts 4 and 5. 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

Select Your Life Insurance Coverage:

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:

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

*Smoking status is only needed for Term Life Insurance products

**Non-smoker rates apply to people who have not used any form of tobacco, tobacco cessation products or marijuana in the past 12 months and who meet Manulife's health standards. Smoker status is determined when your coverage is approved.

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

I hereby designate the individual(s) named as beneficiary(ies) on this application to receive any death benefit payable with respect to the coverage applied for. If no beneficiary is designated, benefits will be payable to the Estate.

Beneficiary(ies):

1. _____ | _____ | _____ | _____
   Last Name | First Name | Relationship to Applicant | % of Benefit

2. _____ | _____ | _____ | _____
   Last Name | First Name | Relationship to Applicant | % of Benefit

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits are paid, the benefits will be paid to the trustee to hold in trust for the child until the child comes of age.

Trustee:

_____ | _____ | _____
Last Name | First Name | Relationship to the beneficiary

A copy, fax, scan or image of the beneficiary designation in this application is as valid as the original.

Parts 4 and 5 must be completed by all Life Insurance applicants and LTD Late Applicants.

Part 4 – Non-Medical Information

Have you:	Member	Spouse (if applicable)
1. Ever applied for any insurance that was declined, modified or rated? If yes, give details including date, name of company and reason: _____	☐ Yes ☐ No	☐ Yes ☐ No
2. a) In the past 5 years, have you been charged with or convicted of careless or dangerous driving or had your license suspended or revoked? If yes, provide details, including the number of charges and convictions and date of last conviction. In case of a license suspension or revocation, provide details including date the license was suspended or revoked.	☐ Yes ☐ No	☐ Yes ☐ No
b) Within the past 2 years, have you been charged with or convicted of 2 or more moving or traffic violations? (for example, speeding, failure to stop, seat belt violations, distracted driving, or failure to provide a breathalyzer sample) If yes, to a) or b) above, please provide full details; nature of offence(s), date(s), driver's license # and licensing province: _____	☐ Yes ☐ No	☐ Yes ☐ No
3. Any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including type of activity and date(s): _____	☐ Yes ☐ No	☐ Yes ☐ No
4 a) Within the next 12 months do you expect to travel outside of Canada and the United States of America? If "yes", give details including where, when, why and for how long: _____	☐ Yes ☐ No	☐ Yes ☐ No
b) Do you expect to change your country of residence? If "yes", provide details, including where you intend move, when you are moving, why you are moving, and if your occupation is changing _____	☐ Yes ☐ No	☐ Yes ☐ No
5. Within the past 5 years, have you used any drugs for other than medical purposes, used marijuana, or have you been advised, treated or counselled for alcohol or drug abuse? If yes, give details including drug or alcohol type(s) and date(s) last used: _____	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past 5 years have you been convicted of a criminal offense or are you currently charged with one? If yes please provide details _____	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 5 years have you declared, or are you contemplating personal or business bankruptcy? If yes, provide details including date of discharge _____	☐ Yes ☐ No	☐ Yes ☐ No

Part 5 – Medical Declaration

Member Information

Name of Applicant:_____ Physician's Name: _____

Physician's Address and telephone number: _____

Date, reason, and result of last consultation, and if any treatment or medication prescribed: _____

Height _____ ft and in/cm Weight: _____ lb/kg

Has your weight changed in the past year? ☐ Yes ☐ No If yes: _____ lb/kg ☐ Gained ☐ Lost

Reason for change: _____

Spouse Information

Name of Applicant:_____ Physician's Name: _____

Physician's Address and telephone number: _____

Date, reason, and result of last consultation, and if any treatment or medication prescribed: _____

Height _____ ft and in/cm Weight: _____ lb/kg

Has your weight changed in the past year? ☐ Yes ☐ No If yes: _____ lb/kg ☐ Gained ☐ Lost

Reason for change: _____

Have you ever had any indication of or been treated for conditions involving any of the following:	Member	Spouse (if applicable)
1. **Your heart or blood vessels**, such as: angina, blood clots, heart disease, bypass or angioplasty, cerebrovascular disease (CVA), stroke or transient ischemic attack (TIA), chest pains or shortness of breath, heart attack, heart murmur, palpitations, high blood pressure, elevated cholesterol, poor circulation, swollen ankles, or other?	☐ Yes ☐ No	☐ Yes ☐ No
2. **Your nose, throat or lungs**, such as: asthma, chronic obstructive pulmonary disease (COPD), chronic or recurrent bronchitis, emphysema, sarcoidosis, sleep apnea, tuberculosis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
3. **Your abdominal organs**, such as: cirrhosis, colitis, Crohn's disease, diverticulitis, gastrointestinal bleeding, gastrointestinal reflux, hepatitis (including hepatitis carrier state), irritable bowel syndrome, liver disease, pancreatitis, ulcer, or other?	☐ Yes ☐ No	☐ Yes ☐ No
4. **Your kidneys, bladder or reproductive organs**, such as: abnormal pap smear, bladder infection, kidney stone, nephritis, prostatitis or other prostate disorder, protein in the urine, urinary tract infection (UTI), sugar or blood in urine, uterine fibroids, polycystic kidney disease, other kidney or bladder disorders, other reproductive disorder or sexually transmitted disease, or other?	☐ Yes ☐ No	☐ Yes ☐ No
5. **Your breast**, such as: abnormal mammogram findings or biopsy, cysts, lumps or other physical changes, or other?	☐ Yes ☐ No	☐ Yes ☐ No
6. **Your brain or nervous system** such as: dizziness, Parkinson's disease, Alzheimer's disease, multiple sclerosis, numbness/tingling, fainting or syncope, seizures, tremor, vertigo, paralysis, or other?	☐ Yes ☐ No	☐ Yes ☐ No
7. **Your eyes or ears**, such as: blindness, blurred vision, deafness, glaucoma, impaired hearing, impaired sight, labyrinthitis, optic neuritis, tinnitus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
8. **Your mental health**, such as: depression, anxiety, stress, burnout, attempted suicide, suicide ideation, any emotional or eating disorder, or other?	☐ Yes ☐ No	☐ Yes ☐ No
9. **Your blood or glands**, such as: Diabetes (including gestational diabetes and impaired glucose), abnormal blood sugar, anemia, bleeding tendency, gout, hemophilia, bleeding tendency, lymph gland disorder, thyroid disorder or other endocrine disorders, or other?	☐ Yes ☐ No	☐ Yes ☐ No
10. **Your muscles, bones, or joints**, such as: chronic fatigue, chronic pain, fibromyalgia, muscular dystrophy, rheumatoid arthritis or osteoarthritis, paralysis or weakness, any injury or disorder of the muscles, bones, joints, or spine causing any physical limitations or restrictions, or other?	☐ Yes ☐ No	☐ Yes ☐ No
11. **Your skin**, such as: basal cell carcinoma, dysplastic nevus or dysplastic nevus syndrome, lesions freckles or moles that have changed in size, colour or have bled, psoriasis, dermatitis, nevus or nevi, or other?	☐ Yes ☐ No	☐ Yes ☐ No
12. **Your immune system**, such as: HIV, AIDS, any generalized enlargement of your lymph glands, any test results indicating possible exposure to HIV or AIDS virus, or other?	☐ Yes ☐ No	☐ Yes ☐ No
13. Cancer, cysts, lumps, polyps, or tumour?	☐ Yes ☐ No	☐ Yes ☐ No
14. Other illness or disorder not mentioned above or, are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment?	☐ Yes ☐ No	☐ Yes ☐ No
15. Are you currently pregnant? If "Yes", give due date and the name and address of your obstetrician/gynecologist: _____ a) What was your pre-pregnancy weight _____ lbs _____ kg	☐ Yes ☐ No	☐ Yes ☐ No
b) Have there been any complications with your pregnancy? If "Yes" provide details. _____	☐ Yes ☐ No	☐ Yes ☐ No
During the past 5 years (Spouses are not required to answer questions 16 to 20):		
16. Have you been told you had, or been investigated, or treated for conditions involving your spine, back or neck, such as: disc disease, pain, strain, sprain sciatica, or other?	☐ Yes ☐ No	☐ Yes ☐ No
17. Had X-rays (including the spine or joints), had an electrocardiogram (ECG), blood test or other diagnostic test?	☐ Yes ☐ No	☐ Yes ☐ No
18. Have you been advised to have any diagnostic test, consultation, hospitalization or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No
19. Been hospitalized or been medically disabled for more than two consecutive weeks?	☐ Yes ☐ No	☐ Yes ☐ No
20. Have you consulted any physician or health practitioner (including but not limited to chiropractor, psychologist, psychiatrist, physiotherapist, ophthalmologist, naturopath, or any other health care worker) for any reason including routine or annual physical examinations or check-ups?	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 2 years:		
21. Had an abnormal mammogram, PSA or any other test or investigation?	☐ Yes ☐ No	☐ Yes ☐ No
22. Consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu, etc.)	☐ Yes ☐ No	☐ Yes ☐ No
23. Been advised to undergo further investigation, seen another doctor or have surgery?	☐ Yes ☐ No	☐ Yes ☐ No
24. Are you presently unable to perform any of the usual duties of your regular occupation due to injury or sickness?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the preceeding questions, please give details below

Question #	Nature of Disorder	Date and Duration	Treatment (If None, State "None") & Current Status	Attending Physician or Hospital

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.

Your Family Medical History	Member	Spouse (if applicable)
1) Have any of your parents or siblings (brothers or sisters) been diagnosed prior to age 60 with heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
2) Have any of your parents or siblings ever been diagnosed with Huntington's chorea, polycystic kidney disease or other kidney disease (excluding kidney stones), Parkinson's disease, multiple sclerosis, Alzheimer's disease, amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neuron disease, diabetes, hepatitis, retinitis pigmentosa or any hereditary disease?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, to 1) or 2) above, please complete the following:

Family Member	Condition (if cancer, specify type)	Age at Onset	Age at Death and Cause, if applicable

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

Part 6 – Your Payment Method and Signatures

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 acknowledge premium deductions are taken one month in advance. 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.cdnpay.ca.

☐ 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 7 – 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. Suicide within two years of the effective date is a risk not covered under the Voluntary Life Plan. 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 AND REVOCATION: 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.

_____ | _____ | _____ | DD/MM/YYYY
Signature of Member | City | Province/Territory | Date

_____ | _____ | _____ | DD/MM/YYYY
Signature of Spouse (if applying for coverage) | City | Province/Territory | 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., 1595 – 16th Avenue, Suite 700, Richmond Hill, ON L4B 3S5

JOHNSON INSURANCE Manulife ONA

538001 001 (Life) 538001 002 (LTD) 01-20

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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.