

# Conversion application for PARA disability and life insurance



Please PRINT clearly.

## 1 Member information

Last name		First name		Middle initial	AMA #
Date of birth (dd-mm-yyyy)		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker Non-smoker means you have not used any tobacco or tobacco cessation products in the last 12 consecutive months.		
Mailing address (street number and name)				Apartment or suite	
City	Province	Postal code	Telephone		
Email address		May we correspond with you via email so that we may contact you for the administration of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date residency program completed (dd-mm-yyyy)		Date you will be commencing full-time medical practice or fellowship training (dd-mm-yyyy)			

## 2 Coverage applied for

I wish to apply for conversion of my PARA insurance to the AMA group plan, as follows:

**Life Insurance coverage**  Yes  No If *yes*, beneficiary for Life Insurance coverage:

Beneficiary last name	Beneficiary First name	Relationship to member
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**Disability Insurance coverage**  Yes  No If *yes*, complete the following:

Please indicate your final postgraduate pay level: <input type="checkbox"/> PGY 2 <input type="checkbox"/> PGY 3 <input type="checkbox"/> PGY 4 <input type="checkbox"/> PGY 5 <input type="checkbox"/> PGY 6 <input type="checkbox"/> PGY 7 <input type="checkbox"/> PGY 8
Do you wish to exercise a <b>Guaranteed Insurability Benefit (GIB) rider</b> increase at this time? (You are automatically issued the GIB rider. This question asks if you want to exercise the GIB rider to increase coverage using the completion of residency option). <input type="checkbox"/> Yes <input type="checkbox"/> No If <i>yes</i> , please complete the GIB application for residents.
Do you wish to add <b>Cost of Living Adjustment rider</b> to any existing AMA Disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to purchase the <b>Own Occupation rider</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If <i>yes</i> , do you wish to add the Own Occupation rider to any existing AMA disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to purchase the <b>Retirement Protection rider</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No

### 3 Declaration and authorization

I declare that my answers are true and complete and I understand that concealment, misrepresentation or false declaration concerning this form will cause this insurance to be void.

I authorize Sun Life Assurance Company of Canada, the plan administrator (ADIUM Insurance Services Inc), and their agents and service providers to use and exchange information needed for administration and adjudicating claims under this insurance coverage with any person or organization who has relevant information about me including institutions, investigative agencies, insurers, and reinsurers.

As a member of the Alberta Medical Association or Northwest Territories Medical Association, I understand and agree that this application is void unless I am in active practice or undertaking fellowship training on the date shown in section 1 of my application.

A photocopy or electronic version of this authorization is as valid as the original.

Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) — —
Signature of member X		

### 4 Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at [www.sunlife.ca](http://www.sunlife.ca), or send a written request by email to [privacyofficer@sunlife.com](mailto:privacyofficer@sunlife.com), or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.

### 5 Mailing instructions

**Please return your completed application to:**

ADIUM Insurance Services Inc.  
CMA Alberta House  
12230 106 Avenue NW  
Edmonton AB T5N 3Z1

Fax: 780-488-7558 or 1-877-302-3486  
Email: [adium@albertadoctors.org](mailto:adium@albertadoctors.org)

**Monthly or Annual pre-authorized payment (PAP)**

Please indicate payment frequency:

- Monthly (interest free)
- Annual (full payment for balance of calendar year and annually the first week of January thereafter)
- Please add payments to my existing pre-authorized payment plan.

Please complete this section if you'd like to have the AMA collect your premium payment(s) directly from your bank account.

**Please include a blank cheque, marked VOID, from the account you wish to be debited, OR complete this section.**

First name of account holder	Middle initial	Last name
Name and address of your financial institution (street number and name)		
Transit #	Institution #	Account #

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the terms and conditions below.

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Signature of account holder <b>X</b>	Date (dd-mm-yyyy) — —
Signature of account holder <b>X</b>	Date (dd-mm-yyyy) — —

**Terms and conditions**

You authorize the Alberta Medical Association (AMA) to collect, depending on your selection, the monthly or annual premium (including applicable provincial tax) for this insurance through a Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement that the AMA notify you of any payments after the first payment whether the amount of the monthly or annual premium is changed or not.** You understand that if you selected the monthly payment option, the monthly premium is due the first of each month; if you selected the annual payment option, the annual premium payment will be due the first of January each year. This agreement will be cancelled automatically if the AMA is unable to make a withdrawal from your account.

This authorization is to remain in effect until the AMA has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca).

The AMA may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

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 debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

ADIUM Insurance Services Inc.  
 CMA Alberta House  
 12230 106 Avenue NW  
 Edmonton, AB T5N 3Z1  
[adium@albertadoctors.org](mailto:adium@albertadoctors.org)