ALBERTA MEDICAL ASSOCIATION

Application for Insurance

Sun Life Financial

For medical student members of the Alberta Medical Association

Please PRINT clearly

In this application you and your refer to the person applying for insurance. We and the Company refer to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

1 General information

AMA #

Last name	First name	Middle initial	☐ Dr. ☐ Mr. ☐ Ms ☐ Mrs. ☐ Miss

Former/maiden name (if applicable)	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
		– –

Mailing address (street number and name)	Apartment or suite

City	Province	Postal code

Telephone	Cell phone number	E-mail address
– –	– –	

Date you started medical school (dd-mm-yyyy)	Date you expect to graduate (dd-mm-yyyy)	What is your current year of medical school?
– –	– –	☐ First ☐ Second ☐ Third ☐ Final

Name of medical school or university

☐ Non-smoker ☐ Smoker	Non smoker means that you have not used any tobacco or tobacco cessation products in the last 12 consecutive months.	May we correspond with you via email so that we may contact you for the administration of this application?	☐ Yes ☐ No

2 Coverage applied for

If you are applying for Disability insurance, please check the box. Your coverage will be as shown, based on your year of medical school.

If you would like to apply for Life insurance, please check the box, and provide your beneficiary information.

Trustee clause for minor children – applies when beneficiary is under age 18.

☐ Student Disability insurance:

First/Second year:
$1,500 monthly benefit
COLA included

Third year:
$2,500 monthly benefit
COLA included

Final year:
$4,000 monthly benefit
COLA included

☐ Term Life insurance – $100,000:

Beneficiary last name	Beneficiary first name	Relationship to you	Indicate age if under 18

Trustee last name	Trustee first name	Relationship to the proposed insured

Please check optional riders desired.

☐ Future Insurance Option rider

☐ Waiver of Premium rider

3 Insurance information

Do you currently have Disability insurance or have you concurrently applied for any Disability insurance coverage provided by individual or group policies?

☐ Yes ☐ No If *yes*, provide full details below:

Amount of benefit	Insuring company	Date of issue (mm-yyyy)	Elimination period (e.g. 90 days)	Benefit period (e.g. to age 65)	Taxable
$		–			☐ Yes ☐ No

Will any Disability insurance be discontinued if the coverage you have applied for is issued?

☐ Yes ☐ No If *yes*, provide details below

Insuring company	Policy number	Amount
		$

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4 Premium payments

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

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

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	Date (dd-mm-yyyy)
X	– –
Signature of account holder	**Date (dd-mm-yyyy)**
X	– –

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. Y**ou 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*.

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*.

ADIUM Insurance Services Inc.
CMA Alberta House
12230 106 Avenue NW
Edmonton, AB T5N 3Z1
adium@albertadoctors.org

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5 Authorization and declaration

Please read and sign this section.

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation or false declaration concerning this application will cause the insurance to be void. As a member of the Alberta Medical Association or the Northwest Territories Medical Association, I understand and agree that this application is void unless I am enrolled full-time in a medical school in Alberta on the date of this application.

I authorize Sun Life Assurance Company of Canada, its agents and service providers, and ADIUM Insurance Services Inc. as the plan administrator, 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.

Your signature X		
Location signed (city)	Location signed (province)	Date (dd-mm-yyyy) – –

Please mail your completed and signed 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

6 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*, or send a written request by e-mail to *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.

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