Ontario Pharmacists Association Enrolment Form

SECTION 1 – Proposed Insured Information (Please print)

1.1 I am applying for:

☐ **OPA Secure Health Plan**
Evidence of insurability application is required with enrolment form.

☐ **OPA Advantage Plus Plan**
Health Spending Account application is required.

1.2

First Name: _____ Last Name: _____

Date of Birth (YEAR / MM / DD): _____

Address: _____

_____

Telephone: _____

E-mail address: _____

Billing Address* (If different from above)

Billing Contact Name: _____

Pharmacy Name: _____

Address: _____

_____

* Non-pharmacist applicant, other than pharmacy technician, must complete billing address

1.3

OPA Member Number: _____

☐ Member pharmacist ☐ Member pharmacy technician ☐ Other staff member

Occupation: _____

Are you now actively engaged in your occupation on a full time basis? ☐ Yes ☐ No

If 'no', provide details: _____ Number of hours worked/week: _____

SECTION 2 – Insurance Coverage (Please Print)

2.1 **To ensure that Eligible Dependents (and only Eligible Dependents) are covered, complete the following information:**

☐ I am applying for Single coverage; **OR**

☐ I am applying for Family coverage and my eligible Dependents are as follows:

Name (First, Middle, Last)	Gender	Relationship to member (Spouse, Child)	Date of Birth (yy/mm/dd)	If 21 or over, is the Child a Student or Disabled?

2.2 **Please indicate below if you, your spouse or your children are covered for Health Care and/or Dental Care under any other Group Insurance Plan**

A. For OPA Secure Health Plan only

☐ I do not have any other coverage

☐ I have other coverage (complete section 2.3)

B. For OPA Advantage Plus Plan only

☐ I do not have any other coverage

☐ I have other coverage and I am applying for full coverage (complete section 2.3)

☐ I have other coverage and I am ***declining*** the insured portion (only HSA portion will be provided)

2.3

Benefit	Yourself	Your Spouse	Your Children	Name of insured, Policy Number & Insurance Co.
Health Care				
Dental Care				

2.4 **Effective Date:** (1st of a month) **Monthly Premium:**

2.5 **Beneficiary Designation**

Unless otherwise designated, this beneficiary appointment is "REVOCABLE."

Province of Quebec Residents Note

The appointment of a spouse as beneficiary is considered "IRREVOCABLE" unless the word "REVOCABLE" is actually written after the spouse's name.

Full First Name and Last Name of Primary Beneficiary	%	Relationship to Insured

Contingent/Secondary Beneficiary (In the event of Beneficiary pre-deceasing Insured)	%	Relationship to Insured

Name of Trustee (If named beneficiaries are children below age 18)	%	Relationship to Insured

SECTION 3 – Agreements and Authorizations

3

Proposed Insured to read this section, sign and date it.

1. I declare that the above statements are true and complete and form part of any certificate issued.

2. I agree that acceptance of any certificate issued on this application constitutes approval of the provisions of the certificate and ratification of any additions or endorsement or amendments.

3. I agree that any certificate issued on the application takes effect only on delivery to the owner and payment in full of the first premium and then only if there has been no change in my insurability, subsequent to the completion of this application.

4. I authorize the Medical Information Bureau, Inc (MIB Inc.) to disclose to Desjardins Financial Security and/or Maximum Benefit or its Reinsurers any personal information or personal health information.

5. I have read and received the Pre-Notice form describing the procedures of the MIB Inc. and the Confidentiality Agreement.

6. I authorize Desjardins Financial Security and/or Maximum Benefit to perform tests, examinations [such as, but not limited to, test for Human Immunodeficiency Virus (HIV), blood profiles and electrocardiogram], as may be required to underwrite this application for insurance. On my written request, the Medical Director of Desjardins Financial Security and/or Maximum Benefit will disclose all medically related information obtained during the underwriting process to my personal physician.

7. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility that I have attended, or any insurance company, MIB Inc., government agency, provincial health care insurer or other organization, institution or person that has any personal information or personal health information relating to me to disclose particulars to Desjardins Financial Security and/or Maximum Benefit, its Reinsurers, its agents, as required, for the purpose of underwriting my application for extended health insurance and for administering any claim.

8. As necessary, for underwriting extended health insurance, or for administering any claim, I authorize Desjardins Financial Security and/or Maximum Benefit to

   a) exchange my personal information or personal health information with each other;

   b) disclose my personal information or personal health information with its/their agents, affiliates, Reinsurers and the Ontario Pharmacists Association;

   c) use my personal information or personal health information in any other files which it/they currently hold(s) respecting me, or which may be opened in the future; and/or

   e) use any existing files, opened or closed, that it/they currently hold(s) respecting me

   f) I acknowledge that further information concerning the collection, use and disclosure of personal information by Ontario Pharmacists Association, Maximum Benefit an Desjardins Financial Security is available through their individual websites listed below, or by request:

      Ontario Pharmacists Association: www.opatoday.com Please click on the topic titled "OPA Privacy Policy"
      Maximum Benefit: http://www.johnstongroup.ca/docs/privacy-enfirst.pdf
      Desjardins Financial Security: www.dfs.ca (search work "Privacy Policy")

A photographic copy of these signed authorizations is as valid as the original.

Insurance is a contract based on trust. Failure to fully disclose facts material to this application can render the contract void.

Signed in the City of: and Province of:

(Date)	(Signature of Proposed Insured)	(Date)	(Signature of Employer)
(Date)	(Signature of Witness)	(Date)	(Signature of Agent)

SECTION 4 – Pre-Authorization Debit Terms and Conditions

4

Proposed Insured's Name:

1. In this Authorization "we" and "our" refer to the premium payor and "Maximum Benefit" refers to the Third Party Administrator (TPA) acting on behalf of Desjardins Financial Security in the administration of premiums due under Desjardins Financial Security Group Policy # 54969.

2. We agree to participate in this direct payment plan for paying variable amounts of premium and other amounts due from us to Maximum Benefit, and we authorize Maximum Benefit to draw a debit in paper, electronic or other form on our Account and Financial Institution branch indicated on the voided cheque.

3. We may revoke this Authorization at any time by delivering a written notice of revocation to Maximum Benefit (with a copy to our Financial Institution). Notice of revocation will be effective 10 days after receipt by Maximum Benefit. This Authorization applies only to the method of payment.

4. Maximum Benefit may revoke this Authorization at any time by delivering a written notice of revocation to us. Such notice will be effective 10 days after mailing. The previous payment method (cheque) will then be in effect.

5. We acknowledge that in the absence of a waiver we are, under the Canadian Payments Association Rules, entitled to at least ten days' notice of the amount of a withdrawal and hereby waive the requirement for the giving of such notice.

6. We may claim for a reimbursement from our Financial Institution (with prior notice to Maximum Benefit) for up to 10 business days after it was posted for the following reasons:

   - this Authorization was never provided to Maximum Benefit
   - the pre-authorized debit was not drawn in accordance with this Authorization
   - this Authorization was revoked
   - the debit was posted to the wrong account due to invalid or incorrect account information supplied by us.

7. We agree that the Financial Institution is not required to verify that any payment has been drawn, in accordance with this Authorization, including the amount, frequency and fulfillment of purpose of any payment.

8. We agree that delivery of this Authorization to Maximum Benefit constitutes delivery by us to the Financial Institution. We agree that Maximum Benefit may deliver this Authorization to our Financial Institution.

9. We certify that all information provided with respect to our Account is accurate and we agree to inform Maximum Benefit, in writing, of any change in our Account information provided in this Authorization, at least 10 business days prior to the next due date for payment.

10. We understand and agree to the terms and conditions set out above, and consent to the collection, use and disclosure of any personal information required to facilitate the pre-authorized debit.

11. We agree to comply with the Canadian Payments Association Rules, or any other rules or regulations which may affect the services described above, as may be introduced in the future or are currently in effect and we agree to execute any further documentation which may be prescribed from time to time by the Canadian Payments Association in respect of the services described above.

Authorizing name (please print):

Date:

Authorizing Signature*:

***The authorizing name and signature must be an individual with signing authority on the selected Bank Account**

PLEASE RETURN THIS FORM WITH A VOIDED CHEQUE TO INDICATE THE ACCOUNT FROM WHICH PREMIUMS ARE TO BE WITHDRAWN

SECTION 5 – Detach and retain for your records

5

Please send completed enrolment form to:

Ontario Pharmacists Association
155 University Avenue, Suite 600, Toronto, Ontario M5H 3B7
(416) 441-0788, Toll Free 1 (877) 341-0788

Pre-Notice regarding the Medical Information Bureau, Inc. (MIB)

Personal information or personal health information obtained will be treated as confidential. Desjardins Financial Security and/or Maximum Benefit or its Reinsurers may, however, make a brief report thereon to the MIB Inc., a non-profit membership organization of the insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Inc. member company for life or health insurance coverage, or make a claim for benefits to such a company, MIB Inc., upon request, will disclose to such company with the personal information or personal health information on file.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any personal information or personal health information it may have in your file. If you question the accuracy of information in the MIB Inc.'s file, you may contact MIB Inc. and seek a correction. The address of MIB Inc. office is:

Medical Information Bureau, Inc
330 University Ave., Suite 501,
Toronto, ON M5G 1R7
(416) 597-0590.

Release of Information

Desjardins Financial Security and/or Maximum Benefit may also disclose, with your authorization to do so, personal information or personal health information, as required, in its/their file(s) to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Confidentiality Agreement

In order to ensure the confidentiality of the personal information or personal health information held concerning you, Desjardins Financial Security and/or Maximum Benefit will establish an insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claim. Only employees or authorized organizations who will be responsible for underwriting, administration, investigations and claims, or any other person whom you authorize, will have access to this file. Your file will be kept in the Desjardins Financial Security and/or Maximum Benefit office(s). You are entitled to consult personal information or personal health information contained in this file and, if applicable, to have it rectified by submitting a written request to the following address:

Maximum Benefit
1051 King Edward Street
Winnipeg, MB
R3H 0R4

OR

Desjardins Financial Security
Contract Administration
200, rue des Commandeurs
C.P. 3000
Levis, QC G6V 9X8