Manulife

OMA Ontario Medical Association

Send completed form to:

Manulife
P.O. Box 17001, Stn Waterloo
Waterloo, ON N2J 0G5

For more information, visit:
omainsurance.com

For questions, please call:
1-888-596-8881

Consent for authorized persons

Use this form to give, change, and/or revoke permission for persons you authorize to contact Manulife on your behalf.

In this form, *we*, *us*, and *our* refer to The Manufacturers Life Insurance Company (Manulife). *You*, *your*, *me*, and *I* refer to the plan member, insured spouse, and/or insured overage dependent.

An insured overage dependent is any insured child age 16 or over. An insured underage dependent is any insured child under 16 years of age.

If you are the spouse or overage dependent of the plan member but you are **not** insured under the policy, please do not complete this form. Instead, the plan member must complete this form and name you as an authorized person.

Authorized persons can include but aren't limited to: your spouse/partner, another family member, your friend, your business associate (such as your office manager or business partner), your financial advisor (such as your accountant or tax advisor), your insurance advisor or broker, the Plan Sponsor, the employer's benefits administrator, the employer's benefits consultant/advisor, or other persons.

IMPORTANT: Completing this form is optional. Each insured person must complete their own form.

Please complete this form carefully. The type of information provided by or to authorized persons depends on the selections you make on this form. Complete this form if the plan member, insured spouse, or insured overage dependent want to give, change, and/or revoke permission for someone to contact Manulife on your behalf, and for Manulife to contact the authorized persons on your behalf. If, on this form, you change and/or revoke consent from authorized persons, we will follow your instructions accordingly. **Note:** Manulife is not responsible for what authorized persons do with the information provided by us.

By completing this form, you agree that Manulife is allowed to share your personal, claims, benefit, and/or other specified information with authorized persons. If you are the plan member, you also agree that Manulife is allowed to share the personal, claims, benefit, and/or other specified information of your insured underage dependents with authorized persons.

This consent **does not** extend to obtaining online account access or related technical support; making any type of change to, or canceling, any policy on the plan member's behalf; nor applying for any services or products on the plan member's behalf.

1 Member information

This section must always be completed.

If only the plan member is giving, changing, and/or revoking consent to/from authorized persons, please complete this section, and then proceed to section 3.

OMA member ID #	PTMA member ID # (if applicable)	
Last name	First name	Middle initial
Former name (if applicable)	Sex ◯ Male ◯ Female	Date of birth (dd/mmm/yyyy)
Home address (street number and name)		Apartment or suite
City/Town	Province	Postal code
Telephone (preferred contact) ◯ Home ◯ Business ◯ Cell ( )		
Email (optional) By providing us your email you are authorizing us to communicate with you by email for business purposes.		

2 Insured spouse or overage dependent's information

Insured spouse or overage dependent: Please complete this section with your information if you are giving, changing, and/or revoking consent to/from authorized persons.

Plan member: Proceed to section 3.

Last name	First name	Middle initial
Relationship to the Plan member. Please select only one option. ◯ Insured spouse ◯ Insured overage dependent		Date of birth (dd/mmm/yyyy)
Home address (street number and name) ◯ same as plan member, or:		Apartment or suite
City/Town	Province	Postal code
Telephone (preferred contact) ◯ Home ◯ Business ◯ Cell ( )		
Email (optional) By providing us your email you are authorizing us to communicate with you by email for business purposes.		

3 Consent designation

This section must always be completed.

Indicate what type of consent changes you want to make on this form. Check all that apply.

- ◯ **New** consent to share or obtain information to/from authorized persons. Please complete section 4.
- ◯ **Change** the current consent of authorized persons. Please complete section 5.
- ◯ **Revoke** current consent from authorized persons. Please complete section 5.

4 New consent (if applicable)

Complete all questions in this section to authorize persons to access your information.

Note: Only the plan member may give, change, and/or revoke an authorized person's ability to access or provide the information of an insured underage dependent.

1. I authorize the following persons to provide, and for Manulife to obtain, information about me and/or my insured underage dependents.

Names of authorized persons (Last, first, middle initial)	Relationship to you	Date of birth (dd/mmm/yyyy)
a)		
b)		
c)		

If you need more space, please complete on separate sheet of paper and sign and date it.

2. **Authorized persons' declaration and authorization**

By signing here, the authorized persons indicate they understand their personal information will be used by Manulife and consent to its collection and use. For more information on Manulife's privacy policies, please visit: manulife.ca/privacy-policies.html.

a)

Signed at (city/town, province)	Date (dd/mmm/yyyy)
Signature of authorized person (a) ✘	

b)

Signed at (city/town, province)	Date (dd/mmm/yyyy)
Signature of authorized person (b) ✘	

c)

Signed at (city/town, province)	Date (dd/mmm/yyyy)
Signature of authorized person (c) ✘	

3. I am the:

- ◯ Plan member > Indicate if you want to authorize the above persons to access or provide:
  - ◯ your information, and/or
  - ◯ information about your insured underage dependents. Provide their names: _____
- ◯ Insured spouse
- ◯ Insured overage dependent

4. Please specify which policies you wish to give your authorized persons permission to access information for:

- ◯ All policies
- ◯ Specific policy numbers. Please provide the policy/plan numbers and ID numbers: _____

5. I give consent for the following types of information to be released to, or provided by, the persons authorized above:

- ◯ All types of information, **or**
- ◯ Only the following types of information. Check all that apply and provide details in question 6.
  - ◯ Status of my application for insurance
  - ◯ Health claims
    - **includes** drug names, claims history or services performed, dates of service, and amounts used
  - ◯ Dental claims
    - **includes** dental procedures performed, claims history, dates of service, and amounts used
  - ◯ Disability claims
    - **includes** claims history and amounts used
    - **excludes** details related to diagnosis, treatment, or medication
  - ◯ Premium and billing information
    - **includes,** but not limited to, the policies' paid-to date
  - ◯ Summary or confirmation of insurance coverage
  - ◯ Schedule of Benefits and Certificate of Insurance
  - ◯ Corporate Ownership Change or Policy Assignment
  - ◯ Beneficiary information

4 New consent (if applicable) (continued)

Complete all questions in this section to authorize persons to access your information.

6. Instructions: Please indicate any specific instructions, details, and/or restrictions about information that may be provided or obtained by the above authorized persons.

5 Change and/or revoke current consent (if applicable)

Complete this section if you wish to change and/or revoke the consent currently provided to authorized persons to access or provide your information.

NOTE: Only the plan member may give, change, and/or revoke an authorized person's ability to access or provide the information of an insured underage dependent.

1. a)

Name of authorized person to change or revoke (Last, first, middle initial)	Relationship to you	◯ Change ◯ Revoke

If changing consent, I now authorize this person to access or provide the information of the:

◯ Plan member > Indicate if you want to authorize the above person to access or provide:

◯ your information, and/or

◯ information about your insured underage dependents. Provide their names: _____

◯ Insured spouse

◯ Insured overage dependent

b)

Name of authorized person to change or revoke (Last, first, middle initial)	Relationship to you	◯ Change ◯ Revoke

If changing consent, I now authorize this person to access or provide the information of the:

◯ Plan member > Indicate if you want to authorize the above person to access or provide:

◯ your information, and/or

◯ information about your insured underage dependents. Provide their names: _____

◯ Insured spouse

◯ Insured overage dependent

c)

Name of authorized person to change or revoke (Last, first, middle initial)	Relationship to you	◯ Change ◯ Revoke

If changing consent, I now authorize this person to access or provide the information of the:

◯ Plan member > Indicate if you want to authorize the above person to access or provide:

◯ your information, and/or

◯ information about your insured underage dependents. Provide their names: _____

◯ Insured spouse

◯ Insured overage dependent

If you need more space, please complete on a separate sheet of paper and sign and date it.

If you are changing consent, complete questions 2, 3, and 4 in this section. If you are only revoking consent, go to section 6.

2. Please specify which policies you now wish to give the above authorized persons permission to provide or obtain information for:

◯ All policies

◯ Specific policy numbers. Please provide the policy/plan numbers and ID numbers: _____

3. I now change my consent for the following types of information to be released to, or provided by, the persons authorized above:

◯ All types of information, **or**

◯ Only the following types of information. Check all that apply and provide details in question 4.

◯ Status of my application for insurance

◯ Health claims
- **includes** drug names, claims history or services performed, dates of service, and amounts used

◯ Dental claims
- **includes** dental procedures performed, claims history, dates of service, and amounts used

◯ Disability claims
- **includes** claims history and amounts used
- **excludes** details related to diagnosis, treatment, or medication

◯ Premium and billing information
- **includes,** but not limited to, the policies' paid-to date

◯ Summary or confirmation of insurance coverage

◯ Schedule of Benefits and Certificate of Insurance

◯ Corporate Ownership Change or Policy Assignment

◯ Beneficiary information

5 Change and/or revoke current consent (if applicable) (continued)

Complete this section if you wish to change and/or revoke the consent currently provided to authorized persons to access or provide your information.

4. Instructions: Please indicate any specific instructions, details, and/or restrictions about information that may now be provided or obtained by the above authorized persons.

6 Declaration and authorization

This form must be sent within 90 days of signing.

Only the insured person who is giving, changing, and/or revoking consent is to sign this form.

If the plan member is **not** giving, changing, and/or revoking consent for themselves and/or insured underage dependents, their signature is not required.

I authorize Manulife to disclose (or not disclose) my information and/or the information of my insured underage dependents (if applicable), as described in this form, to the authorized persons identified on this form.

The authorized persons are authorized until consent is changed or revoked. The insured person signing this form must advise Manulife in writing if changing or revoking consent.

I agree that a photocopy of this authorization shall be valid as the original.

Signed at (city/town, province)	Date (dd/mmm/yyyy)
Signature (plan member, insured spouse, or insured overage dependent) ✘	

The Manufacturers Life Insurance Company (Manulife)