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

Request for cancellation of existing group insurance coverage

For the members of the Ontario Medical Association (OMA), and Atlantic Medical Associations or Societies (PTMA). In this form, *we, us,* and *our* refer to The Manufacturers Life Insurance Company (Manulife). *You, your,* and *I* refer to the insured member.

1 Member information

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 Coverage cancellation

Use this section to cancel coverage. Policy numbers selected in this section will be terminated. Any included riders or special offers will also be terminated.

Note: a minimum amount of Member Life coverage may be required in order to keep a Spouse Life plan active. Please refer to the terms of your contract for details.

Policy numbers

- Your policy number is on your Certificate.
- For Health, Dental and OPIP policies, your plan and ID numbers are on the front of your Benefit card.

◯ Cancel **all** coverage. Please indicate each policy number you wish to cancel.

Member Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Spouse Life	◯ G-3900-0	◯ G-29500-0	◯ G-29700-0	◯ G-29800-0
Disability	◯ 2718	◯ 59997	◯ 17849	◯ 140004
Member Critical Illness	◯ 17862			
Spouse Critical Illness	◯ 17862			
Professional Overhead Expense	◯ 20647	◯ 20638		
Accidental Death and Dismemberment	◯ 95001			
Health/Health Plus	◯ 17884 Plan number: _____ ID number: _____			
Dental/Dental Plus	◯ 17884 Plan number: _____ ID number: _____			
OPIP (all coverage under OPIP will be cancelled)	◯ 50130/50131 Plan number: _____ ID number: _____			

Please indicate a current or future date, do not back date. Cancellation date will be effective the last day of the month the request is received or the requested date indicated below, whichever is later, provided a minimum of 31 days' notice is given.

Cancellation date: Date (dd/mmm/yyyy)

In addition to this request, are you requesting any changes to your existing insurance coverage with form AF1532E, *Request for Change to Existing Group Insurance Form*?

◯ Yes ◯ No

3 Reason for requested cancellation

Tell us why you want to cancel your coverage. Provide any additional details in the space provided.

- ◯ Cost of coverage
- ◯ My needs have changed. I no longer require coverage.
- ◯ Plan features/service. Please provide details below.
- ◯ I have obtained new coverage through:
  - ◯ My employer
  - ◯ Another insurance company
  - ◯ Another medical association

Details/comments

4 Declaration and authorization

By signing below I authorize Manulife to process the requested cancellation outlined above. I understand the implications of the cancellation requested and that Manulife requires at least 10 business days to process cancellation requests. All cancellations are made effective as of the end of the month in which the request is received or the requested date, whichever is later. If a claim is paid out after I request to terminate any health and/or dental coverage, then the benefit will be terminated at the end of the month in which the claim was paid. Once the request has been processed, any premiums owing to me will be refunded, if applicable.

Signed at (city/town, province)	Date (dd/mmm/yyyy)

Signature of policy owner (indicate title of signing officers, if applicable)
✘

Signature of life beneficiary (if irrevocable)	Signature of assignee (if collaterally assigned)
✘	✘

The Manufacturers Life Insurance Company (Manulife)