OAR

Ontario Association of Radiologists

January, 2018

Dear Ontario Radiology Resident/Fellow:

On behalf of Ontario's radiologists, welcome to the radiology residency/fellowship program! You are embarking into the most exciting and continuously changing medical field. The Ontario Association of Radiologists (OAR) is the professional association that represents the interests of Ontario's 900 diagnostic imaging physicians and looks forward to the time when you will be in active practice.

Several years ago, the OAR felt that it was important to provide support to residents and fellows in ways that many of us did not experience when we were in training. Among the initiatives, we have taken were to set up regular meetings with residents to give you a glimpse of issues facing the profession and the provide career advice to those in their final years of training. We have developed a job guide to assist residents and fellows identify job openings, and provide telephone advice to anyone who wishes to call the OAR office. We also provide group contact information and are available to send your curriculum vitae to radiology Chiefs when ready to seek career opportunities. Last year marked the third recipient of the Harald Stolberg Radiology Excellence Fund in memory of the late Dr. Harald Stolberg, a celebrated radiologist educator, to assist a senior resident to attend a centre of excellence to obtain diagnostic imaging skills/expertise that would be brought back to Ontario. All residents and fellows are members of the OAR at no cost during their training and their first year of practice. All are welcome to attend any membership meeting and have complimentary access to most OAR CME events.

In 1999, we created the OAR Insurance Program to provide radiologists with superior quality insurance programs suited to meet your needs with benefits unavailable through the OMA. Our insurance plan has over 690 Radiologists enrolled. **As a resident/fellow, the OAR decided it was important to include you in our no medical disability insurance offer and pay your premium for up to 8 months when combined with the RBC student initiative program when you enroll through our insurance representatives Levine Financial Group. There is a no medical required.**

Disability Program:

- Up to **$4,500 per month**
- **NO** medical required.
- Own occupation coverage.
- Total, residual and partial disability benefits.
- Cost of living adjustment protection.
- Future income option up to $25,000 per month
- HIV and Hepatitis B and C protection.
- Conversion to long term care coverage.
- **Up to 8 months' free coverage**
- **Guaranteed 25-40% discount.**

245 Lakeshore Road East, Oakville, Ontario L6J 1H9
Tel: 905-337-2680 or 800-616-6277 **Fax:** 905-337-2678 or 888-616-6277
E-mail: oar@globalserve.net **Website: www.oar.info**

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Enrollment must be completed before May 30, 2018 through our insurance representatives Levine Financial Group.

Advisors from Levine Financial Group will follow up with you shortly to discuss this limited time special offer. For further information, contact the OAR Insurance program either at our office (see contact numbers below) or call Levine Financial at 416-222-1311 or 1-877-314-1311.

Sincerely,

Raymond Foley
Executive Director

Encl.

** For disability insurance, residents/fellows under 35 are eligible for up to a 40% premium reduction off the initial premium that levels off to a 25% reduction off the ultimate premium at a later age. OAR pays the first 3 months of premium and RBC Insurance student initiative program pays up to 5 months' free coverage for disability insurance.*
No medical at the time of enrollment. Approval is subject to income underwriting and answers on the attached RBC Insurance application. Tax returns may be required in the event of a claim. A 24-month pre-existing condition exclusion amendment applies. If you have used tobacco in the past 12 months, smoker rates will apply.

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LEVINE
FINANCIAL GROUP

Radiology Residents and Fellows - Disability Insurance offer

As a Radiology resident, you are eligible to enroll for up to $4,500 per month ($8,500 for fellows) of *individually owned* disability insurance through the OAR insurance program. **You can enroll with NO MEDICAL, receive up to a 40% discount* and up to 8 months FREE coverage!**

HIGHLIGHTS

- ✓ **Own occupation coverage**
- ✓ **Cost of living adjustment**
- ✓ **Future income option up to $25,000/month**
- ✓ **25-40% discount**.
- ✓ **NO MEDICAL**
- ✓ HIV and Hepatitis B and C protection
- ✓ Conversion to long term care coverage
- ✓ Up to **8 MONTHS FREE** coverage!

WHAT DOES IT COST?

Please find below tables showing your initial monthly premium for $2,500 or $4,500 per month of disability insurance. Your plan includes the own occupation definition of disability, a cost of living adjustment, a future income option, HIV, HEP B&C protection, a conversion to long term care coverage and up to a 40% annual premium discount*

$2,500 per month of coverage		
	Monthly Rate	
Age	Male	Female
20 - 25	$35.48	$58.79
26	$36.85	$63.62
27	$37.77	$67.17
28	$38.83	$69.57
29	$40.05	$72.17
30	$41.45	$74.95
31	$43.05	$77.99
32	$44.77	$81.18
33	$47.00	$84.49
34	$49.55	$87.94
35	$52.36	$91.54

$4,500 per month of coverage		
	Monthly Rate	
Age	Male	Female
20 - 25	$60.39	$100.06
26	$62.72	$108.27
27	$64.27	$114.32
28	$66.08	$118.38
29	$68.15	$122.81
30	$70.54	$127.55
31	$73.25	$132.70
32	$76.17	$138.15
33	$79.98	$143.78
34	$84.32	$149.66
35	$89.04	$155.77

*Doctors under age 35 are eligible for a 40% discount off the initial premium; that levels off to a 25% premium reduction off the ultimate premium at a later age

Attached is the application. Please complete, sign, attach a VOID and scan back to info@levinefinancialgroup.com. If you have any questions please call 416-222-1311.

Insurance

OAR Resident/Fellow Application for Disability Insurance

to RBC Life Insurance Company

PROPOSED INSURED NAME		
Last	First	Middle Initial

PROPOSED INSURED ADDRESS	CITY	PROVINCE	POSTAL CODE

TELEPHONE NUMBER	ALTERNATE CONTACT NUMBER	E-MAIL ADDRESS

DATE OF BIRTH			GENDER	LANGUAGE OF POLICY
Day	Month	Year	Male ☐ Female ☐	English ☐ French ☐

FULL NAME OF BENEFICIARY FOR SURVIVOR BENEFIT	RELATIONSHIP TO PROPOSED INSURED

All beneficiary designations are revocable except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable by checking the following box: ☐ Revocable

DATE JOINED ASSOCIATION	CURRENT YEAR OF STUDY (Circle one)
Sept 2017	**Residency Fellowship**

QUESTIONNAIRE	YES	NO
1. Are you a Canadian Citizen or a Permanent Resident (landed immigrant)?.....	☐	☐
2. In the past 12 months, have you used cigarettes, e-cigarettes, more than one large cigar per month, water pipes, betel nuts more than once a month, smoking cessation products or nicotine or tobacco in any other form?.....	☐	☐
3. Are you now, or in the past 180 days, have you been unable to work or attend school continuously on a full-time (30 hours per week) basis in the usual and customary manner performing all of the duties of your occupation or studies, or have you been homebound more than 5 days and/or hospitalized due to an accident or sickness?.....	☐	☐
4. In the past 5 years, have you received any treatment, medical advice, been diagnosed with or required any follow-up for: Depression, post-traumatic stress disorder, bipolar disorder, suicidal thoughts or attempts, hallucinations, psychosis, chronic fatigue syndrome, dysthymia, bulimia, anorexia nervosa, agoraphobia, fibromyalgia, chronic pain syndrome or are you currently taking any anti-depressant or anti-anxiety medication?.....	☐	☐
5. Has an insurance company ever denied you disability insurance under an individual, group or association plan?.....	☐	☐
6. Do you currently have the total loss of: your power of speech, or your hearing in both ears, or sight in both eyes, or the use of both hands, or the use of both feet, or the use of one hand and one foot?.....	☐	☐

Please provide details of "YES" answer to question 6:

COVERAGE APPLIED FOR

PLAN NAME	BENEFIT AMOUNT	ELIMINATION PERIOD	BENEFIT PERIOD	BENEFITS	
The Professional Series® **Level Premium** ☐ **Step Rate Premium** ☐	$_____	**90 Days**	**To Age 65**	**Mandatory**	**Health Care Profession Benefit** **Future Income Option** **FIO Unit of Increase $** _____
				Optional	**Cost of Living Adjusted Benefit** ☐ **Disability in Your Occupation Benefit** ☐

COMPLETE, SCAN AND EMAIL TO INFO@LEVINEFINANCIALGROUP.COM

7. PLEASE COMPLETE THE FOLLOWING TABLE IF YOU HAVE ANY INDIVIDUAL, GROUP OR ASSOCIATION DISABILITY INSURANCE IN FORCE OR PENDING OTHER THAN THE COVERAGE BEING APPLIED FOR WITH RBC LIFE. IF THE TABLE IS LEFT BLANK, YOU ARE CONFIRMING THAT YOU HAVE NO OTHER DISABILITY INSURANCE IN FORCE OR PENDING (OTHER THAN RBC LIFE).				
COMPANY	**AMOUNT OF MONTHLY BENEFIT**	**TYPE (GROUP, INDIVIDUAL, ASSOCIATION)**	**TAXABLE?**	**ARE YOU REPLACING THIS COVERAGE WITH THE COVERAGE APPLIED FOR IN THIS APPLICATION?**
			Yes ☐ No☐	
			Yes ☐ No ☐	

DECLARATIONS AND CONSENTS (Please review and sign)

It is understood and agreed as follows:

1) The Pre-Authorized Debit (PAD) form and a deposit for one month of premium are required in order to activate any coverage. If no deposit is being provided, I authorize RBC Life Insurance Company (RBC Life) to withdraw the initial premium by PAD;
2) I have read all the foregoing statements and answers. They are all true and complete. They are part of this application and any individual policy issued as a result.
3) No agent or broker has authority to waive the answer to any question, to determine insurability, to waive any rights or requirements, or to make or alter any contract or policy.
4) RBC Life may be entitled to render this policy null and void if there is misrepresentation or non-disclosure in any part of this application that is material to the insurance risk.
5) Any policy issued as a result of this form shall become effective on the Date of Issue provided that: (a) the policy has been tendered for delivery to the Proposed Owner; and (b) the answers provided on this application have not changed from the date of this application to the Date of Issue date; and (c) the initial premium required has been paid. I will immediately advise RBC Life in writing, of any changes in the answers to the questions in this application between the time of this application and the delivery of the policy.
6) If applicable, any policy issued as a result of this application shall be subject to a group/association offset amendment and/or a pre-existing conditions amendment (which contains a coverage exclusion based on my pre-existing health), and/or a travel exclusion (which limits coverage while travelling outside of Canada or the United States). If individual disability coverage is part of a Wage Loss Replacement Plan, the policy will include a Wage Loss Replacement Amendment.
7) I acknowledge that if I answered "yes" to question six (6), I will not be covered under the Presumptive Total Disability Benefit provision that is contained in the policy issued to me, for the specific condition(s) that require question six (6) to be answered "yes".
8) I acknowledge that if I answered "yes" to question four (4), any coverage issued will include an exclusion for any psychiatric or emotional disorder, including but not limited to, depression, anxiety, stress, burn out or substance abuse, chronic fatigue syndrome, chronic pain syndrome or fibromyalgia. I understand that I may apply to have this exclusion removed after I have been symptom free and received no health related advice or treatment from a physician, psychiatrist, psychologist, counsellor or any other healthcare practitioner, for a minimum period of 5 (five) years. Removal of the exclusion is subject to an application at that time, evidence of insurability and RBC Life approval.
9) I understand that when RBC Life determines the amount of insurance coverage that it will issue, they will rely on the information I have given in Section 7 about any existing or pending disability coverage. I acknowledge that if I either do not discontinue coverage that I have indicated will be replaced or I have not disclosed all existing coverage (other than RBC Life), the benefits under this policy may be reduced or not provided at all.
10) The actual amount RBC Life will issue will be based on the maximum amount I qualify for, any other disability coverage in force or pending that is not being replaced or cancelled and RBC Life Issue and Participation Limits. RBC Life is not required to specifically notify me if the amount applied for and the amount issued is different.
11) RBC Life shall not be liable for any claim on account of any benefits applied for, commencing prior to the effective date of coverage. Notwithstanding any interim premium payments, no temporary or conditional insurance is being provided to either the proposed insured or the proposed owner.
12) Acceptance of any policy issued as a result of this application form will ratify my acceptance of any differences in the terms of coverage between the policy wording and as stated in this form.
13) I have read the section entitled "Collection and Use of Personal Information" appearing in this application and I understand and agree to its terms.

SIGNATURE:

Proposed Insured: _____ Date: _____
(Day, Month, Year)

SIGN HERE

Date (dd/mm/yy)		
Advisor's Signature		
Advisor's Name		
Advisor's Company Name	Levine Financial Group	
Marketing Office / MGA		
Share		Servicing Advisor Code: 52014

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Pre-Authorized Debit (PAD) Agreement

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Life) is authorized to make scheduled monthly withdrawals to pay the premium in accordance with the premium schedule set out in this policy/policies, including the initial premium, against the account at the financial institution below, or any other financial institution that the Payor(s) may later designate.

   (b) **RBC Life is not required to provide notification before the initial premium is debited, or if the amount of withdrawal should vary.**

   (c) unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy/policies.

   (d) the financial institution indicated below is authorized now or at any subsequent time to honour any requests made by RBC Life to withdraw premium or fees from the account indicated below, which may include a redraw within 30 days should any withdrawal not clear the account,

   (e) notification of any change to the information provided below, shall be given to RBC Life by the Payor(s), at a minimum of 5 days prior to the next scheduled withdrawal. The Payor(s) agrees that from time to time they may authorize RBC Life to deduct such payments from another account upon the Payor's oral or written instructions.

   (f) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Life or by the Payor(s). The Payor(s) may obtain further information on their right to cancel a PAD agreement by visiting the Canadian Payments Association website at www.cdnpay.ca."

   (g) In the event that a PAD is disputed, the Payor(s) agrees to contact RBC Life. For recourse purposes, this PAD is considered a Personal PAD.

   The Payor(s) has certain recourse rights if any debits do not comply with this agreement. For example, the Payor(s) has the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on recourse rights, the Payor(s) may contact their financial institution or visit www.cdnpay.ca.

   (h) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAD with policy number(s) _____

3. Special Requests (withdrawals are limited between the 1st – 28th of the month) _____

Bank Information:

Please attach a sample cheque marked void (a line of credit account cannot be used).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number

Address _____

City _____ Province _____ Postal Code _____

Dated at _____ (city/province) this _____ day of _____ (month) _____ (year)

_____
Print Name of Payor (Account Holder)

_____
Signature of Payor **SIGN HERE**

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