

Application

Prism Precision® and Prism Continuum®

For Office Use Only

Badge Number	Approved By	Source/Agent I.D. Number 1491
Effective Date	Billing Division Number	GS I.D. Number

Part A Plan selection

You, your spouse/partner and all listed dependents must have Provincial Government Health Care coverage to purchase any of these plans.

1 I/We apply for Single Couple Family

2 **PRISM PRECISION®**

P1 P2 P3

Yes. Please add Semi-Private Hospital Accommodation (Additional premium required)

PRISM CONTINUUM® (You must be leaving a Company Group Health Plan to be eligible for this program)

C1 C2 C3

Part B Individuals to be covered

All 3 sections must be completed for the applicant, spouse/partner and dependent children

1 Last Name	2 First Name Initial	3 Sex	Birth Date			Age
			Year	Month	Day	
Applicant		E				
Spouse/Partner		S				
Dependent Child		C				
Dependent Child		C				
Dependent Child		C				

Please print clearly

Dependent children must be under age 21

Part C Mailing address

Last Name _____ First Name _____ Initial _____

Apt. No _____ Street Address _____

City or Town _____ Prov. _____ Postal Code _____

Home Telephone () _____ Business Telephone () _____

E-mail Address _____

If additional information is required, how may we contact you during our regular business hours?

Home Telephone Business Telephone Mail (Canada Post) E-mail Address

Status Single Couple Family Other _____ Applicant's Occupation: _____

Part D Other coverage

1 Are you covered, or were you covered by an Individual Health Plan? Yes No

If "Yes", when does/did your Individual Health Plan end? MM DD YYYY _____

Name of Insurance Company _____

2 Are you covered, or were you covered by a Group Health Plan within the last 60 days? Yes No

If "Yes", when does/did your Group Health Plan end? MM DD YYYY _____

Name of Insurance Company _____

ID# _____ Previous Employer's Name _____

Part E

Account/
Banking
information

- 1 Is this a joint account? Yes No
- If "Yes", does this joint account require only one signature? Yes No
- 2 Name of account holder(s) if different from applicant _____
Address of account holder(s) if different from applicant _____
- 3 Name of contact person (Signing Officer for company) _____

Initial
payment

Applications cannot be processed without the first two months payment plus one of the account holder's cheques marked "Void".
NOTE: We cannot accept line of credit or Visa/MasterCard cheques for pre-authorized payments.

**Please make cheque payable to:
"Green Shield Canada"**

Part F

Pre-
authorized
payment

I/We hereby authorize Green Shield Canada to **withdraw premium payments from my/our account thirty (30) days in advance of the due date**, on or about the first business day of each month. Should there be any change in either the amount or premium due date, Green Shield Canada will give the applicant written notice of at least thirty (30) days in advance. Green Shield Canada may terminate coverage should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. **This authorization shall remain valid unless written notice is received by Green Shield Canada, ten (10) business days prior to the next pre-authorized debit due date** requesting cancellation by either the applicant or account holder(s).

Signature of Account Holder **X** _____ Date _____
MM DD YYYY

2nd Signature if Joint Account **X** _____ Date _____
MM DD YYYY

Important: First Bank Withdrawal – Refer to the enclosed General Information Booklet for banking information.

Part G

Hospitalization
statement

- 1 a) Do you, your spouse/partner or any listed dependent children expect to be hospitalized in the next six months?
Applicant: Yes No Spouse/Partner: Yes No Dependent Children: Yes No
- b) Are you, your spouse/partner or any listed dependent(s) pregnant? Yes No

If you answered "Yes" to this question, please give details below

Name of person	Anticipated date of stay	Anticipated number of days in hospital	Details of illness or injury

Claims submitted are audited to verify accuracy of the medical information provided (Prism Precision® with Semi-Private Hospital Accommodation only)

Part H

Authorization
to be signed
by applicant
and spouse/
partner
(If applicable)

NOTE: The information provided on this form is confidential.
By signing this application form, I/we agree that the statements contained herein are true and complete, to the best of my/our knowledge and form the basis for any coverage approved. I am authorized to release information concerning my spouse/partner and my dependent children, for the purposes of determining their eligibility for benefits.

I/We understand that the coverage shall not become effective until the first of the month following approval by Special Benefits Insurance Services Agency Inc. and/or Green Shield Canada. I/We authorize any physician, dentist, medical practitioner, hospital, clinic or other medical or medical related facility, insurance company, or other organization, institution or person that has any records or knowledge of my health, and that of my spouse/partner and any listed dependent children, to exchange any such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Special Benefits Insurance Services Agency Inc. and/or Green Shield Canada. A reproduction of this consent and authorization shall be as valid as the original.

Signature of Applicant **X** _____ Date _____
MM DD YYYY

Signature of Spouse/Partner **X** _____ Date _____
MM DD YYYY

Green Shield
Canada's
commitment
to privacy

Your personal information is collected for the purpose of providing you with health and dental benefits, claims analysis and payments. For information on Green Shield Canada's privacy policies and procedures, visit greenshield.ca

