

# Application

Prism Spectra®

## For Office Use Only

Badge Number	Approved By	Source/Agent I.D. Number <b>01491</b>
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 SPECTRA®**  
 S1  S2  S3  
 Yes. Please add Semi-Private Hospital Accommodation (Additional premium required)

## 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) if company account \_\_\_\_\_

## Initial payment

**Applications cannot be processed without the initial two months payment plus one of the account holder's cheques marked "Void". NOTE: We cannot accept line of credit or credit card 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 \_\_\_\_\_ Date \_\_\_\_\_  
MM DD YYYY

2nd Signature if Joint Account \_\_\_\_\_ Date \_\_\_\_\_  
MM DD YYYY

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

## Part G

Prescription drug information

**1** Do you, your spouse/partner or any listed dependent children currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs?  Yes  No

**NOTE: Prescription drugs include oral medication, injectables, creams, drops or serum**

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

Name of person	Name of the drug/medication/serum/cream	Strength	Daily dosage	Length of time on this drug/medication/serum/cream	# of refills per year	Monthly cost of the drug/medication/serum/cream
						\$
						\$
						\$
						\$

Missing information will delay the processing of your application

**NOTE: If additional space is required, please attach a separate sheet.**

# Part H

Statement of health for applicant, spouse/partner and dependent children

**1** Have you, your spouse/partner or any listed dependent children been hospitalized in the last two years?  
 Applicant:  Yes  No Spouse/Partner:  Yes  No Dependent Children:  Yes  No

**2** 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 question 1 or 2, please give details below**

Name of person	Date of illness, injury or confinement	Number of days in hospital	Details of illness or injury

**NOTE: If additional space is required, please attach a separate sheet.**

**3** Have you, your spouse/partner or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of any of the following conditions?

(Check  Yes or  No for all questions And **circle** the specific medical condition if applicable)

- Yes  No a) Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures or Paralysis
- Yes  No b) ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)
- Yes  No c) Stomach, Intestinal, Kidney, Bladder or Liver Disorder (Including Hepatitis)
- Yes  No d) Infertility, Reproductive Disorder or Menopause
- Yes  No e) Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia, Reflux or persistent Heartburn
- Yes  No f) Circulatory, Heart or Vascular Disease, High Blood Pressure, Angina, Stroke or T.I.A. (Mini Stroke)
- Yes  No g) Elevated Cholesterol
- Yes  No h) Alcoholism or Drug Dependency
- Yes  No i) Skin Disorder (Including Acne, Rosacea, Psoriasis and Eczema)
- Yes  No j) AIDS, ARC (AIDS Related Complex), HIV or other Immunological Disorders
- Yes  No k) Arthritis/Rheumatism, Osteoporosis, Bone Density Loss, Back, Joint or Muscle Pain
- Yes  No l) Lung Condition, Respiratory Condition including COPD, Asthma or Allergies
- Yes  No m) Headaches/Migraines
- Yes  No n) Cancer, Tumour or Leukemia
- Yes  No o) Sexually Transmitted Disease or Infection (STD's or STI's) or recurring Infections (Including Cold Sores/Herpes)
- Yes  No p) Diabetes, Endocrine, Hormonal or Thyroid Disorder
- Yes  No q) Glaucoma
- Yes  No r) Any other Conditions, Diseases, Disorders or Injuries not listed above – Please specify \_\_\_\_\_

**If you answered "Yes" to any of the conditions in Question 3, please give details below**

Name of person	Diagnosis	Date(s) diagnosed	Name of the Drug/Treatment	Date of last treatment or prescription filled

**NOTE: If additional space is required, please attach a separate sheet.**

**Claims submitted are audited to verify accuracy of the medical information provided.**

## Part I Physician & Dentist information

- 1 Have you, your spouse/partner or any listed dependent children consulted a **physician** annually over the last two (2) years?

Applicant:  Yes  No Spouse/Partner:  Yes  No Dependent Children:  Yes  No

Provide the name and telephone number of the physician who holds the majority of your health records  
(If you do not have a doctor, indicate "None")

Name of Physician/Medical Clinic Telephone Number ( )

- 2 Have you, your spouse/partner or any listed dependent children visited a **dentist** on a regular basis over the last two (2) years?

Applicant:  Yes  No Spouse/Partner:  Yes  No Dependent Children:  Yes  No

Provide the name and telephone number of your dentist. (If you do not have a dentist, indicate "None")

Name of Dentist Telephone Number ( )

- 3 Do you, your spouse/partner or any listed dependent children plan to visit a dentist in the next two (2) months?

Applicant:  Yes  No Spouse/Partner:  Yes  No Dependent Children:  Yes  No

If "Yes", please indicate dental work to be done \_\_\_\_\_

**NOTE: If the proposed dental work is expected to exceed \$300 a detailed treatment plan is required from your dentist before your treatment begins.**

## Part J 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. **Failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependent children could result in denial of a claim and the cancellation or modification of this coverage.**

I/We understand that it is my/our obligation to inform Special Benefits Insurance Services Agency Inc. of a change in my health and that of my spouse/partner and any listed dependent children due to either injury or illness which occurs after the date of application and prior to the effective date of the policy.

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

**Additional medical information may be required to underwrite your application.**

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](http://greenshield.ca)**

**GREEN SHIELD**  
CANADA



Providing marketing and administration for  
Green Shield Canada's Prism® Health and Dental Programs

Make cheque payable to Green Shield Canada  
Mail **completed** application and cheques to:  
McGowan Insurance Services Ltd  
391 March Cres  
Oakville, ON L6H 5X7