Application

PRISM SPECTRA®

SPECIAL BENEFITS
INSURANCE SERVICES

Green Shield Canada

For Office Use Only

Badge Number	Source/Agent I.D. Number
	1491
Effective Date	GS I.D. Number
Approved by:	

SECTION A Coverage Information (Please print clearly or type)

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

I/We apply for ◯ Single coverage ◯ Couple coverage ◯ Family coverage

I/We apply for the following **PRISM SPECTRA®** plan: ◯ **S1** ◯ **S2** ◯ **S3** ◯ **S4**

❑ **YES**. Please include Hospital Accommodation (Approval and additional premium required)

Are you covered, or were you covered under any other health plan? ◯ **YES** ◯ **NO**

If yes, please indicate if coverage was: ◯ Group ◯ Individual

When does/did your coverage end? (MM/DD/YYYY) ____/____/____

Name of insurance carrier: _____

ID#_____ Previous Employer's Name: _____

SECTION B Individuals to be Covered (Please print clearly or type)

NOTE: **Dependent children must be under age 21 to qualify for coverage.**

Last Name	First Name	Middle Initial		Gender M/F	Date of Birth (MM/DD/YYYY)	Age
Applicant			E			
Spouse/ Partner			S			
Dependent Child			C			
Dependent Child			C			
Dependent Child			C			

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

SECTION C Mailing Information (Please print clearly or type)

Last Name: First Name: Middle Initial:

Street Address: Apt. No:

City/Town: Prov. Postal Code:

Home Phone: ( ) Business: ( ) Cell: ( )

Email:

If additional information is required, how may we contact you during our regular business hours? (Monday to Friday, 8:45 am to 4:45 pm ET)

❑ Home Telephone ❑ Business Telephone ❑ Mail (Canada Post) ❑ Email

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

SECTION D General Health Information (Please print clearly or type)

PART A

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/symptom of ANY of the following:

Check ☑ **YES** or ☑ **NO** for all questions **AND** (circle) the specific medical condition

A) Depression, Anxiety, Sleep Disorder, Seizures, Alzheimer's, Dementia, or any other Neurological or Mental Health/Emotional Disorders . . . . . ☐ **YES** ☐ **NO**

B) ADD (Attention Deficit Disorder), ADHD (Attention Deficit Hyperactivity Disorder), or ODD (Oppositional Defiant Disorder) . . . ☐ **YES** ☐ **NO**

C) Stomach/Bowel Disorder i.e. IBS/IBD (Irritable Bowel Syndrome/Disease), Colitis, Crohn's, Ulcer, Hernia, Reflux, GERD (Gastroesophageal Reflux Disease) or Persistent Heartburn . . . . . ☐ **YES** ☐ **NO**

D) Menopause (including Peri), Infertility, Reproductive Disorder, PCOS (Polycystic Ovary Syndrome) . . . . . ☐ **YES** ☐ **NO**

E) High Blood Pressure, Heart, Circulatory, Artery/Vascular Disease/Condition including PAD (Peripheral Artery Disease), PVD (Peripheral Vascular Disease), Angina, Stroke/Mini-Stroke or TIA (Transient Ischemic Attack) . . . . . ☐ **YES** ☐ **NO**

F) Elevated Cholesterol . . . . . ☐ **YES** ☐ **NO**

G) Alcoholism or Drug Dependency . . . . . ☐ **YES** ☐ **NO**

H) Skin Disorder (including Acne, Rosacea, Psoriasis and Eczema) . . . . . ☐ **YES** ☐ **NO**

I) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), HIV (Human Immunodeficiency Virus), Liver Disorder (including Hepatitis), MS (Multiple Sclerosis) or other Immunological Disorders . . . . . ☐ **YES** ☐ **NO**

J) Osteo or Rheumatoid Arthritis, Back, Joint or Muscle Pain, Fibromyalgia, Gout, Bone Density Loss or Osteoporosis . . . . ☐ **YES** ☐ **NO**

K) Asthma, Allergies, Lung or Respiratory Condition including COPD (Chronic Obstructive Pulmonary Disease), Bronchitis or Emphysema . . . . . ☐ **YES** ☐ **NO**

L) Headaches or Migraines . . . . . ☐ **YES** ☐ **NO**

M) Cancer, Tumour or Leukemia . . . . . ☐ **YES** ☐ **NO**

N) Cold Sores/Herpes, STD's or STI's (Sexually Transmitted Disease or Infection) or any other recurring infections . . . . . ☐ **YES** ☐ **NO**

O) Diabetes, Endocrine, Thyroid, Hormonal Disorder or Lupus . . . . . ☐ **YES** ☐ **NO**

P) Glaucoma . . . . . ☐ **YES** ☐ **NO**

Q) Prostate, Bladder (including Urinary Incontinence) or Kidney Disorder. . . . . ☐ **YES** ☐ **NO**

R) Any other Conditions, Diseases, Disorders, Injuries, Symptoms or have a referral/test/investigation/results pending not listed above - please specify

PART B

If you answered "YES" to any of the condition(s) in SECTION D Part A, please identify which question (letter(s) A-R) and provide details below:

Question	First name of person	Diagnosis/Symptom	Date(s)	Name of the drug treatment/test	Date of last treatment, test 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.

SECTION E Prescription Drug Information (Please print clearly or type)

Do you, your spouse/partner or any listed dependent children currently take or use any prescription drugs, including birth control, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? ◯ YES ◯ NO
(Prescription drugs include, but are not limited to, samples, oral medication, injectables, creams, drops or serums.)

If you answered "**YES**" to this question, please provide details below:

First name of person	Name of drug	Strength	Daily dosage	Length of time using the drug	Number of refills per year	Date of last refill (MM/DD/YYYY)	Approx. monthly cost

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

SECTION F Statement of Health (Please print clearly or type)

NOTE: It is important that you answer all three (3) of the following questions:

1. Have you, your spouse/partner or any listed dependent children been hospitalized in the last two (2) years? ◯ YES ◯ NO

2. Do you, your spouse/partner or any listed dependent children expect to be hospitalized in the next six (6) months? ◯ YES ◯ NO

3. Are you, your spouse/partner or any listed dependent children pregnant? ◯ YES ◯ NO

If you answered "YES" to any of the above questions please provide details below:

First name of person	Date of illness, injury or confinement	Number of days in hospital	Details of illness or injury	Diagnosis/Follow-ups

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

SECTION G Medical and Dental Information (Please print clearly or type)

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**" and reason why)_____

Name of Physician _____ Telephone Number (_____) _____

Have you, your spouse/partner and/or any listed dependent children had a medical exam within the last two (2) years? . . . . . ◯ YES ◯ NO

If you answered "**NO**" please indicate date of last medical exam(s)

Do you, your spouse/partner and/or any listed dependent children plan to visit a dentist in the next three (3) months?. . . . . ◯ 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.

SECTION H Payment Information (Please print clearly or type)

Payment for the first two (2) months of coverage is due on your coverage effective date. All future payments will be made thirty (30) days in advance of the month for which coverage is to be provided.

Is this a personal or business account?: ◯ Personal ◯ Business

Is this a joint account? If "**YES**" does this joint account require two (2) signatures ◯ **YES** ◯ **NO**

If two (2) signatures are required please provide information for both account holders

1st Account Holder Name:

Address:

City/Town: Prov.: Postal Code:

Telephone Number: ( )

2nd Account Holder Name:

Address:

City/Town: Prov.: Postal Code:

Telephone Number: ( )

IMPORTANT: Applications cannot be processed without a "Void" cheque or a PAD form from your bank.

NOTE: We cannot accept line of credit or credit card cheques for pre-authorized payments.

I/We hereby authorize Green Shield Canada to withdraw the initial two (2) months' premium from my/our Financial Services Account (Pre-Authorized Debit). Payment for the first two (2) months of coverage is due on the coverage effective date. **Subsequent payments will be made thirty (30) days in advance of the month for which coverage is to be provided.**

I/We hereby authorize Green Shield Canada **to withdraw premium payments from my/our account specified on the attached void cheque or PAD form thirty (30) days in advance of the due date**, on or about the first (1st) 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 of such change. 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 requesting cancellation by either the applicant or account holder **is received by Green Shield Canada/ Special Benefits Insurance Services at the address shown below, ten (10) business days prior to the next pre-authorized debit due date**.

Special Benefits Insurance Services, 366 Bay Street, 7th floor, Toronto, ON M5H 4B2

I/We understand that I/we may obtain a sample cancellation form or more information regarding my/our right to cancel this Pre-authorized Debit (PAD) Agreement at either my/our financial institution or by visiting cdnpay.ca.

I/We understand that I/we have certain recourse rights if any debit does not comply with this PAD Agreement, and that I/we may either obtain a form for reimbursement claim or more information regarding my/our recourse rights by contacting my/our financial institution or by visiting cdnpay.ca.

Signature of Account Holder (required) ✘ Date MM DD YYYY

Signature of Second Account Holder (if applicable) ✘ Date MM DD YYYY

SECTION I Declarations and Authorizations

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 dependant children, for the purposes of determining their eligibility for benefits.

I/We understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependant 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 (1st) of the month following approval by or on behalf of 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 ✘ Date MM DD YYYY

Signature of Spouse/Partner ✘ Date MM DD YYYY

COVERAGE PROVIDED BY GREEN SHIELD CANADA

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

Email ***completed*** application and void cheque/PAD form to: **general@sbis.ca**

Mail ***completed*** application and void cheque/PAD form to:

McGowan Insurance Services Ltd
391 March Cres, Oakville ON L6H 5X7

ADVISORS REPORT – For Advisor/Agent Use Only		
I confirm that I have disclosed the following information to the applicant: the name of the company or companies I represent; that I receive commissions for the sale of health and dental products and may receive bonuses or other incentives; and any conflicts of interest I may have with respect to this transaction.		
Advisor Name (first and last): Don McGowan	Code: 1491	Advisor signature: