

Application

**PRINT
IN
INK**

**Group Conversion
For Individual Health
and Dental Benefits**

*Please complete
both sides of
the application.*

| For Office Use Only | | |
|---------------------|-------------|-----------|
| Badge # | Approved by | Source |
| Effective Date | Group # | GS I.D. # |

Part A Plan Choice

Are You Covered by a Provincial Health Care Plan? YES NO

I /We Apply For Single Couple Family Coverage

NOTE: THIS PLAN HAS RESTRICTED DRUG FORMULARIES.

GROUP CONVERSION PLAN (guaranteed coverage) - Extended Health, Dental & Semi-private Hospital Accommodation

Part B Individuals to be covered

Applicant, Spouse and Dependent Children Information

Please provide us with the first name and initial of all family to be covered, plus last name of any members if different from the applicant's.

| | Last Name | First Name | Initial | Code | Sex | Birth Date | | | Age |
|-----------------|-----------|------------|---------|------|-----|------------|-------|-----|-----|
| | | | | | | Year | Month | Day | |
| Applicant | | | | E | | | | | |
| Spouse | | | | S | | | | | |
| Dependent Child | | | | C | | | | | |
| Dependent Child | | | | C | | | | | |
| Dependent Child | | | | C | | | | | |
| Dependent Child | | | | C | | | | | |

Part C Mailing Address

Last Name _____ First Name _____ Initial _____

Apt. No. _____ Street Address _____

City or Town _____ Prov. _____ Postal Code _____

Home Telephone (_____) _____ Business Telephone (_____) _____

Marital Status Single Couple Family Applicant's Occupation: _____

Part D Other Individual Coverage

Are you currently covered by another Individual Health Plan? YES NO

If "YES", original effective date _____ Name of Insurance Company _____

When does/did your existing Individual Health & Dental Benefits end? _____

Are you covered, or were you covered by a Green Shield Group plan within the last 60 days? YES NO

If "YES", when does/did your Green Shield Group benefits end? _____

Group # _____ Account # _____ Personal ID # _____

Part E Initial Payment

Important: First Bank Withdrawal - Refer to the enclosed "Rate Sheet" for details regarding your first bank withdrawal.

Amount submitted with my application to cover the first two month's payment is \$ _____

Please make cheque payable to: "Green Shield Canada"

NOTE: Applications cannot be processed without the first two month's payment plus one of your personal cheques marked "Void".

Part F Pre- authorized Payment

I hereby authorize Green Shield Canada to withdraw premium payments from my account 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 me 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 be in no way held liable should such an event occur. The authorization shall remain valid unless written notice is received by Green Shield Canada, 10 business days prior to the next pre-authorized debit due date requesting cancellation by the account holder(s).

Signature of Account Holder *X* _____ Date _____

2nd Signature if joint account *X* _____ Date _____

Please complete reverse side.

Part G Statement of Health for Applicant Spouse and Dependent Children

- 1** Have you, or any listed dependent been hospitalized in the last two years?
Applicant: YES NO Spouse/Dependent Children: YES NO
- 2** Do you, or any listed dependent expect to be hospitalized in the next three months?
Applicant: YES NO Spouse/Dependent Children: YES NO
- 3** Have you, or any listed dependent EVER been treated for, consulted or received advice from a physician or specialist about any of the following conditions (check the appropriate box if "YES")
- | | | |
|---|--|---|
| <input type="checkbox"/> Mental or Brain Disorder, Alzheimer, Parkinson's, Memory loss or Dementia, Seizures or Paralysis | <input type="checkbox"/> Circulatory, Heart or Vascular Disease, High Blood Pressure, Angina, Stroke or Elevated Cholesterol | <input type="checkbox"/> Aids, ARC (Aids Related Complex) or other Immunological Disorder |
| <input type="checkbox"/> Stomach, Intestinal, Liver, Kidney or Bladder Disorder | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Back or Joint Disorder |
| <input type="checkbox"/> Infertility/Reproductive Disorder | <input type="checkbox"/> Alcoholism or Drug Abuse | <input type="checkbox"/> Emphysema or Asthma |
| <input type="checkbox"/> Diabetes, Colitis or Crohn's | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Headaches/Migraines |
| | | <input type="checkbox"/> Cancer, Tumor or Leukemia |

If you answered "YES" to question 1 or 2, or checked any of the boxes in question 3, please give details below

| First Name Only | Condition | Duration and Date | Drugs/Treatment | Results |
|-----------------|-----------|-------------------|-----------------|---------|
| | | | | |
| | | | | |
| | | | | |

- 4** Have you, or any listed dependent been treated for or referred to a specialist or to another physician for a second opinion for any other condition not listed in "Question 3"? YES NO

If "YES", please state condition

Part H Prescription Drug Information

NOTE: PLANS HAVE RESTRICTED DRUG FORMULARIES.

- 1** Are you, or any listed dependent - a) Currently taking or using any prescription drugs including oral medication, injectibles, creams, drops or serum? YES NO
- b) Have a prescription for which refills are currently authorized? YES NO
- c) Expect to be using any prescription drugs? YES NO

If you answered "YES" to question 1 a), b) or c), please complete this section:

| First Name Only | Name of Medication | Monthly Cost | Strength | Daily Dosage | Length of Time Used |
|-----------------|--------------------|--------------|----------|--------------|---------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

NOTE
Missing information will delay the processing of your application.

Part I Dental Information

- 1** Have you and all listed dependents visited your dentist on an annual basis over the last three (3) years? YES NO
- 2** Name and Address of your family dentist (if you do not have a dentist, indicate "NONE")
Name of Dentist _____ Phone # () _____
- 3** Do you or any listed dependents plan to visit your dentist within the next two (2) 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.

Part J Authorization to be signed by all Applicants

NOTE: The information provided on this form is confidential.
The statements contained herein are true and complete and form the basis for any coverage approved. **Failure to disclose or falsifying information regarding my health and/or that of my spouse and/or dependents, could result in a denial of a claim and the cancellation of my coverage.** I/We understand that the coverage shall not become effective until approved by Special Benefits Insurance Services and 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 me or my health, to give Green Shield Canada, any such information as it pertains to this insurance.
A reproduction of this consent and authorization shall be as valid as the original.

Signature of Applicant X _____ Date _____

Signature of Spouse X _____ Date _____

**Return this application to MORNEAU SOBECO, 895 Don Mills Road, Suite 700 Toronto, ON M3C 1W3
Always attach a cheque for two months premium payable to Green Shield Canada and a sample cheque marked "VOID".**