

## Application for Insurance - PHS Basic, Plus or SELECT Programs

Please submit this Application and the Personal Health Declaration with a cheque marked "VOID". For more information or assistance in completing this application, or to request additional applications & health statements, please contact the Program Administrator toll-free at **1-866-809-6753** or visit our website at **www.worldinsurance.com**

### Section 1: General Information

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> OTHER _____		
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH		PRIMARY OCCUPATION	
HOME ADDRESS			CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE		WORKPLACE TELEPHONE		FAX	
EMAIL ADDRESS			YOUR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> INCORPORATED		
YOUR COMPANY NAME		YOUR BUSINESS ADDRESS		CITY	PROVINCE POSTAL CODE
YOUR AGENT / BROKER'S NAME (IF APPLICABLE)		AGENT / BROKER'S TELEPHONE:		AGENT / BROKER'S E-MAIL ADDRESS:	
AGENT / BROKER'S ADDRESS:			CITY	PROVINCE	POSTAL CODE

### Section 2: Coverage Selection & Plan Choice

1. Please indicate your level of coverage:

- Single       Two Parent Family with \_\_\_\_\_ Child / Children  
 Couple       Single Parent Family with \_\_\_\_\_ Child / Children

2. Please choose your Benefits Program:

- PHS BASIC       PHS PLUS       PHS SELECT

3. Please choose Extended Health Care ONLY or Extended Health Care + Dental:

- EHC ONLY       EHC + DENTAL

### Section 3: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 21
Spouse:				
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED

If a Child is over age 21, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

**If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:**

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
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### Section 4: Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

I authorize the Plan Administrator, World Insurance Services LTD., to withdraw from my financial institution the required insurance premiums, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary date of August 1st each year.

Signed at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
 CITY / TOWN PROVINCE DATE MONTH YEAR

### Section 5: Privacy & Confidentiality

We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to World Insurance Services LTD., the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Mail or Fax your completed application to:

**World Insurance Services LTD.**  
**7080 River Road**  
**Suite 201**  
**Richmond, BC V6X 1X5**



**Toll free: 1-866-809-6753**  
**Phone: (604) 248-2698**  
**Fax: (604) 606-3399**  
**E-mail: phs@worldinsurance.com**

## Section 6: Optional Benefits

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. A separate application form is required and can be found in the following pages. However, **please indicate here which Optional Benefits you will be applying for:**

**Temporary Total Disability Benefits:** Requires separate Application Form. Please complete the Income Protection Program Application that follows.

**Permanent Total Disability Benefits:** Requires separate Application Form. Please complete the Income Protection Program Application that follows.

**Critical Illness Benefit:** Requires separate Application Form. Please complete the Income Protection Program Application **AND** ACE INA Health Statement.

**Accidental Death & Dismemberment:** Requires separate Application Form. Please complete the Income Protection Program Application that follows.

## Section 7: Calculate your Monthly Cost: (not including Optional Benefits)

Enter amounts from our web site for the desired plan. The cost of any Optional Benefits you have selected will be added to this amount, and the total amount will be withdrawn from your financial institution each month. Please attach a cheque marked "VOID" to enable these monthly withdrawals.

Your Total  
Monthly  
Benefits Cost: \$

### Notes:

1. All levels of coverage require you to complete the attached **Personal Health Declaration** in order to be approved for coverage.
2. You may also choose to enhance your coverage with one of the four **Optional Benefits** mentioned above. If so, please complete the separate **PHS Income Protection Program** application form.
3. Coverage commences only after the Plan Administrator confirms your acceptance in writing. Coverage may be amended or surcharged based on the information provided in the Personal Health Declaration and any pre-existing conditions.
4. **Please remember to attach a cheque marked "VOID" to enable monthly premium payments.**

