Health Assist Application

FOR INDIVIDUAL HEALTH AND DENTAL COVERAGE

GREEN SHIELD CANADA

SECTION A MAILING ADDRESS AND CONTACT INFORMATION

LAST NAME:	FIRST NAME:	INITIAL:
APT. NO:	STREET ADDRESS:	
CITY/TOWN:	PROVINCE:	POSTAL CODE:
HOME TEL: ( )	BUSINESS TEL: ( )	CELL: ( )
EMAIL ADDRESS:		

SECTION B COVERAGE INFORMATION

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

- ☐ **Single coverage** *Applies to applicant only*
- ☐ **Couple coverage** *Applies to applicant and spouse/partner **OR** applicant and one dependent child under age 21*
- ☐ **Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

Select one plan option:

- ☐ **BASIC**
- ☐ **SELECT**

A: Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No

B: If yes, please indicate if coverage was a: ☐ Group health plan ☐ Individual health plan

C: When did your coverage end? YYYY/MM/DD:

D: Name of insurance carrier:

Add optional Semi-Private Hospital Accommodation

☐ Yes ☐ No

TOTAL MONTHLY PREMIUM:

$

SECTION C INDIVIDUALS TO BE COVERED

LAST NAME	FIRST NAME	INITIAL	GENDER	DATE OF BIRTH YYYY/MM/DD	AGE
APPLICANT:			☐ MALE ☐ FEMALE		
SPOUSE/PARTNER:			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

FOR ADVISOR USE ONLY

ADVISOR ID:	ADVISOR NAME:
MGA/OFFICE CODE:	OFFICE NAME:

FOR GSC USE ONLY

ADVISOR ID:	BD:
MGA CODE:	APPROVED BY:
EFFECTIVE DATE:	

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SECTION D STATEMENT OF HEALTH AND PRESCRIPTION DRUG INFORMATION

1 Have you, your spouse/partner and/or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of the following conditions? (Check ✔, "Yes" or "No" for all questions **AND** **circle** the specific medical condition if applicable.)

		APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
A:	Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures or paralysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B:	ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C:	Stomach, intestinal, kidney, bladder or liver disorder including hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D:	Infertility, reproductive disorder or menopause	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E:	Colitis, Crohn's, irritable bowel syndrome, ulcers, hernia, reflux or persistent heartburn	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
F:	Circulatory, heart or vascular disease, high blood pressure, angina, stroke or TIA (mini-stroke)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
G:	Elevated cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
H:	Alcoholism or drug dependency	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
I:	Skin disorders including acne, rosacea, psoriasis or eczema	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
J:	AIDS, ARC (AIDS related complex), HIV or other immunological disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
K:	Arthritis/rheumatism, osteoporosis, bone density loss, back, joint or muscle pain	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
L:	Lung condition, respiratory conditions including COPD, asthma or allergies	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
M:	Headaches or migraines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N:	Cancer, tumor or leukemia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
O:	Sexually transmitted diseases or infections (STDs or STIs) or recurring infections including cold sores or herpes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
P:	Diabetes, endocrine, hormonal or thyroid disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Q:	Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
R:	Other condition, disease, disorder or injury not listed above – please check (✔) Applicant, Spouse/Partner or Dependent(s) and specify below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

....

If you answered "Yes" to any condition(s) in SECTION D-1 above, please identify which question [letter(s) A–R] and provide details below:

QUESTION LETTER	FIRST NAME OF PERSON	DATE(S) DIAGNOSED YYYY/MM	DRUGS / TREATMENT	NATURE OF ILLNESS, INJURY OR CONDITION AND RESULTS OF TREATMENT

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

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SECTION D CONTINUED...

2 Do you, your spouse/partner and/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
Prescription drugs include oral medication, injectables, creams, drops or serum.

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

PRESCRIPTION DRUG INFORMATION

FIRST NAME OF PERSON	NAME OF DRUG	STRENGTH	DAILY DOSAGE	LENGTH OF TIME USING THIS DRUG	NUMBER OF REFILLS PER YEAR	DATE OF LAST REFILL YYYY/MM/DD

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

		APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
3	Have you, your spouse/partner and/or any listed dependent children been hospitalized in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Do you, your spouse/partner and/or any listed dependent children expect to be hospitalized in the next six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to question 3 or 4, please provide details below:

FIRST NAME OF PERSON	DATE OF ILLNESS, INJURY OR CONFINEMENT YYYY/MM	ACTUAL OR ANTICIPATED NUMBER OF DAYS IN HOSPITAL	DETAILS/OUTCOME OF ILLNESS OR INJURY

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

		APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
5	Have you, your spouse/partner and/or any listed dependent children consulted a physician annually over the last two (2) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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: (   )

Green Shield Canada reserves the right to perform claim audits from time to time to verify the accuracy of health information provided.

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SECTION E PAYMENT INFORMATION

1 ACCOUNT / BANKING INFORMATION

Is this a joint account? ☐ Yes ☐ No

If "Yes", does this joint account require more than one signature? ☐ Yes ☐ No

Name and address of account holder(s) (if different from applicant):

LAST NAME:	FIRST NAME:	INITIAL:
STREET ADDRESS:	CITY/TOWN:	PROVINCE:
POSTAL CODE:	TELEPHONE: ( )	

2 INITIAL PAYMENT / METHOD OF PAYMENT / FIRST BANK WITHDRAWAL

A cheque payable to "Green Shield Canada" is enclosed in the amount of $ __________ , to cover the first **two (2)** months' premiums. (Use Monthly Premium from SECTION B multiplied by 2). Premiums are withdrawn on or about the first day of each month and are payable monthly in advance by pre-authorized withdrawal from your bank account. **The first bank withdrawal will be made one (1) month after your effective date**. e.g. Coverage effective January 1st – initial payment covers January and February benefits; first bank withdrawal will be February 1st for the benefit month of March.

3 PRE-AUTHORIZED PAYMENTS

- I/We understand that coverage shall not become effective until the first of the month following approval by Green Shield Canada.
- 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 at least thirty (30) days in advance.
- Green Shield Canada may terminate coverage should a premium withdrawal be refused for any reason and the financial institution shall not in any 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 due date requesting cancellation by the applicant or account holder(s).

Signature of account holder: .... DATE YYYY/MM/DD: ....

2nd Signature if joint account: .... DATE YYYY/MM/DD: ....

SECTION F DECLARATIONS AND AUTHORIZATIONS

NOTE: THIS AUTHORIZATION MUST BE SIGNED BY THE APPLICANT AND SPOUSE/PARTNER (IF APPLICABLE). 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/or 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 notify Green Shield Canada of a change in the health of anyone listed in SECTION C due to either injury or illness which occurs after the date of application and prior to the effective date of coverage.
- 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, or that of my spouse/partner or any listed dependents, to exchange such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Green Shield Canada.
- A reproduction of this consent and authorization shall be as valid as the original.

Signature of applicant: .... DATE YYYY/MM/DD: ....

Signature of spouse/partner: .... DATE YYYY/MM/DD: ....

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.