Application for Insurance - SELECT Program

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 the numbers listed on our web site.

Section 1: General Information

YOUR NAME (LAST NAME / FIRST NAME / INITIAL)				MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ COMMON-LAW ☐ OTHER ________
DATE OF BIRTH (DD/MM/YYYY)	SEX ☐ MALE ☐ FEMALE	LANGUAGE ☐ ENGLISH ☐ FRENCH		PRIMARY OCCUPATION
HOME ADDRESS	CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE	WORKPLACE TELEPHONE	FAX		
EMAIL ADDRESS	YOUR EMPLOYMENT STATUS ☐ EMPLOYEE ☐ SOLE PROPRIETOR ☐ CONTRACTOR ☐ INCORPORATED			
YOUR COMPANY NAME	YOUR BUSINESS ADDRESS	CITY	PROVINCE	POSTAL CODE

ASSOCIATION: NAICHI

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. You are applying for the SELECT Benefits Program:

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:				☐ STUDENT ☐ DISABLED
Child:				☐ STUDENT ☐ DISABLED
Child:				☐ STUDENT ☐ DISABLED
Child:				☐ STUDENT ☐ DISABLED
Child:				☐ STUDENT ☐ 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

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 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: ____________________ (CITY / TOWN), ________________ (PROVINCE) this _______ (DATE) day of ________________ (MONTH), _____________ (YEAR) Applicant's Signature ______________________________

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, 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 using the contact information provided on our web site.

Section 6: Monthly Premium Rates (choose SELECT coverage, and any Optional Benefits)

Calculate your monthly premium:

From our web site, select your province of residence, and age group. Select the appropriate category for yourself (single, couple, family with children, single parent). Transfer the prices to the appropriate boxes, and add on any additional coverages you would like. Add the boxes that apply together, and enter the sum in the last box. This will be your monthly premium. We will advise you of any errors.

☐ SELECT Program Monthly Rates: (For Families with more than 4 children, please call for a Rate Quote)

Instructions:
To determine your monthly rate for **SELECT** coverage, copy the amount for your age band and level of coverage to box (2) to the right.

SELECT Health Benefits Monthly Cost: $________(1)

☐ Catastrophic Drug Protection Monthly Rates: (Optional; can be added to any program)

Catastrophic Drug Protection is designed to provide additional protection for potential catastrophic drug claims that go beyond the coverage of the plan selected. The rider will extend payment of drug claims that may exceed the limits of the underlying prescription drug benefit of the plan selected (Basic $3,000 / Plus $4,000 / SELECT $5,000) to $25,000 per person ($100,000 Family maximum)

Catastrophic Drug Protection Monthly Cost: $________(2)

Section 7: 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 8: Calculate your Monthly Cost: (not including Optional Benefits)

Total the amounts from boxes (1), and (2) to determine your monthly benefits cost. 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** mentionned above. If so, please complete the separate **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.**