Health Assist Application

FOR INDIVIDUAL HEALTH AND DENTAL COVERAGE

healthassist ZONE

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*

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

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

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

D: Name of insurance carrier:

.....

Select one plan option:

- ☐ **PLAN 1**
- ☐ **PLAN 2**
- ☐ **PLAN 3**
- ☐ **PLAN 4**
- ☐ **PLAN 5**
- ☐ **PLAN 6**

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 CODE:	ADVISOR NAME:
OFFICE CODE:	OFFICE NAME:
MGA CODE:	MGA NAME:

FOR GSC USE ONLY	
ADVISOR CODE:	BD:
OFFICE CODE:	EFFECTIVE DATE:
MGA CODE:	APPROVED BY:

Complete SECTION D if you are applying for Plan 4, 5 or 6 **OR** if you have selected the optional Semi-Private Hospital Accommodation benefit. Otherwise, proceed to SECTION E.

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.

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 medications, 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: ( )

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

SECTION E 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.
- I/We understand that 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 GSC 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 dependent children, to exchange such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with GSC.
- 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: .....

GSC'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 GSC's privacy policies and procedures, visit greenshield.ca.

SECTION F PAYMENT INFORMATION

Payment for the first two months of coverage is due when you are approved. Subsequent payments will be made 30 days in advance of the month for which coverage is to be provided. For example, if your coverage is effective on March 1, you would pay for March and April upon approval. Depending on how you chose to pay, we will withdraw payment from your bank account or charge your credit card for your May coverage on or about April 1.
Payee contact: E-mail: healthassist@greenshield.ca Tel: 1.855.722.0472

METHOD OF PAYMENT

☐ Pre-authorized credit card ☐ Mastercard ☐ Visa ☐ American Express

Name (as it appears on card): Credit Card Number: Expiry:

ADDRESS: CITY/TOWN: PROVINCE: POSTAL CODE:

☐ Pre-authorized Debit **PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID" – Applications received without a "VOID" cheque cannot be processed.**

Is this account Personal or Business? ☐ Personal ☐ Business

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

If two signatures are required, information for both Account Holders must be provided:

1st Account Holder	2nd Account Holder
NAME:	NAME:
ADDRESS:	ADDRESS (IF DIFFERENT FROM 1ST PAYOR):
CITY/TOWN: PROVINCE: POSTAL CODE:	CITY/TOWN: PROVINCE: POSTAL CODE:
TELEPHONE NUMBER: ( )	TELEPHONE NUMBER: ( )

PAYMENT AUTHORIZATION

I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.cdnpay.ca.

I/We hereby authorize GSC to withdraw premium payments from the account specified above on or about the first business day of the month as outlined in SECTION F above.

Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change.

GSC may terminate coverage in the event that a premium withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur.

I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized debit due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel this Pre-Authorized Debit Agreement can be found at my/our financial institution or by visiting www.cdnpay.ca.

I/We represent and warrant that the banking and account information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

Signature of Account Holder: ..... DATE YYYY/MM/DD: .....

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