gsc healthassist®

# CORE

Application for **CORE** Health Coverage

# Green Shield Canada (GSC)

**All applicants must complete SECTIONS A, B, C and SECTIONS E and F. If you are applying for CORE plans 3, 4 or 5, AND/OR the optional Hospital Accommodation benefit, please also complete SECTION D.**

## SECTION A — Contact Information

| | | |
|---|---|---|
| Last Name: | First Name: | Initial: |
| Street Address: | | Apt. No: |
| City/Town: | Province: | Postal Code: |
| Home Tel: ( ) | Business Tel: ( ) | Cell: ( ) |
| ***Email Address** (so GSC can contact you quickly about your application and benefits): | | |

## 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:**

- ☐ **CORE 1**
- ☐ **CORE 2**
- ☐ **CORE 3**
- ☐ **CORE 4**
- ☐ **CORE 5**

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

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

C: When does or did your coverage end? (YYYY/MM/DD):

D: Name of insurance carrier:

☐ Add optional Hospital Accommodation (Please complete SECTION D)

**Total Monthly Rate: $**

## SECTION C — Individuals to be Covered — please complete in full for EACH person

| 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 (first and last): | Advisor Email Address: |
| Office Code: | Office Name: | Advisor Telephone Number: |
| MGA Code: | MGA Name: | |

Individual Health & Dental Plans

gsc green shield canada

Plans provided by **Green Shield Canada (GSC).**

 **Please complete SECTION D if you are applying for CORE plans 3, 4 or 5, AND/OR if you have selected the optional 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: | Anxiety, Depression, Insomnia, ADD/ADHD, Eating disorders or any other Emotional, Mood, Behavioral or Mental health disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| B: | Alzheimer's disease, Dementia, Parkinson's disease, Seizures/Epilepsy, Loss of consciousness, Multiple Sclerosis, Paralysis or any other Neurological disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| C: | Kidney stones, Kidney Disease, Interstitial Cystitis, Benign Prostatic Hyperplasia (BPH) or any other Kidney, Bladder or Prostate disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| D: | Liver disorders, including Hepatitis | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| E: | Infertility, Ovarian cyst, PCOS, Uterine Fibroids, Irregular menses, Menopause or any other Reproductive or Breast disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| F: | Crohn's disease, Ulcerative Colitis, Irritable bowel syndrome, Ulcer, Hernia, Persistent heartburn/Reflux or any other Gastrointestinal disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| G: | Heart disease, Stroke/TIA (mini-stroke), Heart attack, Irregular heartbeat, Angina, High blood pressure, Elevated cholesterol or any other Circulatory, Heart or Vascular disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| H: | Alcoholism or Drug dependency | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| I: | Skin disorders, including acne | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| J: | HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| K: | Arthritis, Osteoporosis/Osteopenia, Back pain, Joint pain, Muscle pain, Fibromyalgia or any other Joint, Bone, or Muscular disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| L: | Allergies, Asthma, COPD, Chronic Bronchitis, Emphysema, or any other Respiratory or Lung disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| M: | Chronic headaches or Migraines | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| N: | Basal cell carcinoma, Growths, Polyps, Tumors, Leukemia or any other Cancers | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| O: | Cold sores, Herpes or any other Sexually transmitted diseases or infections (STDs or STIs) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| P: | Diabetes/Elevated Glucose, Hypothyroidism, Hyperthyroidism, Adrenal Fatigue or any other Endocrine, Hormonal or Thyroid disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Q: | Glaucoma, Cataracts, Meniere's disease or any other Eye, Ear, or Balance disorders | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| R: | Any 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 |
|---|---|---|---|---|
| | | | | |
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**NOTE:** If additional space is required, please attach a separate signed and dated sheet.

**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 | Drug Identification Number (DIN) | Strength | Daily Dosage | Length of Time Using This Drug | Number of Refills Per Year | Date of Last Refill (YYYY/MM/DD) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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**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 | Illness/Injury Treated | Date of Illness, Injury or Confinement (YYYY/MM) | Actual or Anticipated Number of Days in Hospital | Details/Outcome of Illness or Injury |
|---|---|---|---|---|
| | | | | |
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**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.

 **Reminder: BOTH Payment Authorization AND Declaration sections must be signed.**

## SECTION E — Payment Information (Applications without payment cannot be processed)

Your first payment for one month's premium will be taken when your application is approved. The next payment (for one month's premium) will be taken on or about your coverage start date (your coverage effective date), depending on the day of the week the first of the month falls. This ensures your payments (and benefits!) are secure a month in advance. Subsequent payments are taken on or around the first of every month. You can begin using your Health Assist benefits on your coverage effective date. Questions about payments? Call 1.800.268.6613, ext. 4460.

**Choose ONE 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"

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.payments.ca. I/We hereby authorize GSC to withdraw payments from the account specified above on or about the first business day of the month as outlined 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 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 payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.payments.ca. I/We represent and warrant that the payment 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.

X **Signature(s) Required:**

Signature of Account Holder: ..... Date (YYYY/MM/DD): .....

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

## SECTION F — Declarations and Authorizations — ALL APPLICANTS MUST SIGN

**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, and together with any other forms signed by me/us in connection with this application, 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. If I/we apply for a medically underwritten plan, I/we understand that my/our policy will not cover any injury or medical condition that predates the effective date of coverage. It is my/our obligation to notify GSC of any change in the health of anyone listed in this application 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 for the purpose of this application, to administer benefit claims, to provide access to other GSC services, and/or to confirm the accuracy of the information with GSC. I/We acknowledge that all information provided to GSC may be shared with the licensed advisor connected with this application for the purposes identified above, and for policy administration purposes. I/We understand that my/our personal information may also be shared with GSC service providers that require this information to perform their services, as is reasonably necessary, for the purposes identified above. Additional information on GSC's privacy policies and procedures is available online at www.greenshield.ca. A reproduction of this consent and authorization shall be as valid as the original.

X **Signature(s) Required:**

Signature of Account Applicant: ..... Date (YYYY/MM/DD): .....

Signature of Spouse/Partner: ..... Date (YYYY/MM/DD): .....

## ADVISOR'S REPORT – For Advisor/Agent Use Only

I confirm that I have disclosed the following information to the applicant: the name of the company or companies I represent; that I receive commissions for the sale of health and dental products and may receive bonuses or other incentives; and any conflicts of interest I may have with respect to this transaction.

| Advisor Name (first and last): | Advisor Code: | X Advisor Signature: |
|---|---|---|
| | | |

**Please send applications to GSC, Individual Products Team, 5140 Yonge St., Suite 2100, Toronto, ON M2N 6L7**