Application

Prism Spectra®

For Office Use Only		
Badge Number	**Approved By**	**Source/Agent I.D. Number**
		SBIS -W
Effective Date	**Billing Division Number**	**GS I.D. Number**

Part A
Plan selection

You, your spouse/partner and all listed dependents must have Provincial Government Health Care coverage to purchase any of these plans.

1. I/We apply for ☐ Single ☐ Couple ☐ Family

2. **PRISM SPECTRA®**
☐ S1 ☐ S2 ☐ S3 ☐ S4
☐ Yes. Please include Hospital Accommodation **(Approval and Additional premium required)**

Part B
Individuals to be covered

Please print clearly

Dependent children must be under age 21

All 3 sections must be completed for the applicant, spouse/partner and dependent children

1 Last Name	2 First Name	Initial	3	Birth Date Sex	Year	Month	Day	Age
Applicant			E					
Spouse/Partner			S					
Dependent Child			C					
Dependent Child			C					
Dependent Child			C					

Part C
Mailing address

Last Name First Name Initial

Apt.# Street Address

City/Town Prov. Postal Code

Home Telephone ( ) Business Telephone ( )

E-mail Address

If additional information is required, how may we contact you during our regular business hours?

☐ Home Telephone ☐ Business Telephone ☐ Mail (Canada Post) ☐ E-mail Address

Status ☐ Single ☐ Couple ☐ Family ☐ Other _____ Applicant's Occupation:

Part D
Other coverage

1. Are you covered, or were you covered by a **Group Health Plan** within the last 60 days? ☐ Yes ☐ No

If "Yes", when does/did your Group Health Plan end? MM DD YYYY

Name of Insurance Company

ID# Previous Employer's Name

2. Are you covered, or were you covered by an **Individual Health Plan?** ☐ Yes ☐ No

If "Yes", when does/did your Individual Health Plan end? MM DD YYYY

Name of Insurance Company

Part E
Account/ Banking information

1. Is this a personal or business account? ☐ Personal ☐ Business

2. Is this a joint account? If "Yes", does this joint account require two signatures? ☐ Yes ☐ No

If two signatures are required, please provide information for both account holders.

Name of 1st Account Holder (if different from applicant)

Apt.# Street Address

City/Town Prov. Postal Code

Name of 2nd Account Holder (if different from applicant)

Apt.# Street Address

City/Town Prov. Postal Code

Initial payment

Applications cannot be processed without the initial two months payment plus one of the account holder's cheques marked "Void".
NOTE: We cannot accept line of credit or credit card cheques for pre-authorized payments.

Please make cheque payable to: "Green Shield Canada". Post dated cheques will not be accepted.

Part F
Pre-authorized payment

I/We hereby authorize Green Shield Canada **to withdraw premium payments from my/our account specified on the attached void cheque 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 of at least thirty (30) days in advance of such change. Green Shield Canada may terminate coverage should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur.

This authorization shall remain valid unless written notice requesting cancellation by either the applicant or account holder **is received by Green Shield Canada/ Special Benefits Insurance Services at the address shown below, ten (10) business days prior to the next pre-authorized debit due date**.

Special Benefits Insurance Services, 366 Bay Street, 7th floor, Toronto, ON M5H 4B2

I/We understand that I/we may obtain a sample cancellation form or more information regarding my/our right to cancel this Pre-authorized Debit (PAD) Agreement at either my/our financial institution or by visiting cdnpay.ca.

I/We understand that I/we have certain recourse rights if any debit does not comply with this PAD Agreement, and that I/we may either obtain a form for reimbursement claim or more information regarding my/our recourse rights by contacting my/our financial institution or by visiting cdnpay.ca.

Signature of Account Holder ✗ Date MM DD YYYY

2nd Signature if Joint Account ✗ Date MM DD YYYY

Important: First Bank Withdrawal – Refer to the enclosed General Information Booklet for banking information.

Part G
Prescription drug information

Missing information will delay the processing of your application

1. Do you, your spouse/partner or any listed dependent children currently take or use any prescription drugs, including birth control, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? ☐ Yes ☐ No

NOTE: Prescription drugs include oral medication, injectables, creams, drops or serum

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

Name of person	Name of the drug/ medication/ serum/cream	Strength	Daily dosage	Length of time on this drug/ medication/ serum/cream	# of refills per year	Monthly cost of the drug/medication/ serum/cream
						$
						$
						$

NOTE: If additional space is required, please attach a separate sheet.

Part H

Statement of health for applicant, spouse/ partner and dependent children

1 Have you, your spouse/partner or any listed dependent children been hospitalized in the last two years?

Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No Dependent Children: ☐ Yes ☐ No

2 a) Do you, your spouse/partner or any listed dependent children expect to be hospitalized in the next six months?

Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No Dependent Children: ☐ Yes ☐ No

b) Are you, your spouse/partner or any listed dependent(s) pregnant? ☐ Yes ☐ No

If you answered "Yes" to either question 1 or 2, please give details below

Name of person	Date of illness, injury or confinement	Number of days in hospital	Details of illness or injury

NOTE: If additional space is required, please attach a separate sheet.

3 Have you, your spouse/partner or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of any of the following conditions?

Check ✓, Yes or No for all questions and **circle** the specific medical condition (if applicable)

☐ Yes ☐ No a) Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures or Paralysis

☐ Yes ☐ No b) ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)

☐ Yes ☐ No c) Stomach, Intestinal, Kidney, Bladder or Liver Disorder (including Hepatitis)

☐ Yes ☐ No d) Infertility, Reproductive Disorder or Menopause

☐ Yes ☐ No e) Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia, Reflux or persistent Heartburn

☐ Yes ☐ No f) Circulatory, Heart or Vascular Disease, High Blood Pressure, Angina, Stroke or T.I.A. (Mini Stroke)

☐ Yes ☐ No g) Elevated Cholesterol

☐ Yes ☐ No h) Alcoholism or Drug Dependency

☐ Yes ☐ No i) Skin Disorder (including Acne, Rosacea, Psoriasis and Eczema)

☐ Yes ☐ No j) AIDS, ARC (AIDS Related Complex), HIV or other Immunological Disorders

☐ Yes ☐ No k) Osteo or Rheumatoid Arthritis, Osteoporosis, Bone Density Loss, Back, Joint or Muscle Pain

☐ Yes ☐ No l) Lung Condition, Respiratory Condition including COPD, Asthma or Allergies

☐ Yes ☐ No m) Headaches/Migraines

☐ Yes ☐ No n) Cancer, Tumour or Leukemia

☐ Yes ☐ No o) Sexually Transmitted Disease or Infection (STD's or STI's) or recurring Infections (including Cold Sores/Herpes)

☐ Yes ☐ No p) Diabetes, Endocrine, Hormonal or Thyroid Disorder

☐ Yes ☐ No q) Glaucoma

☐ Yes ☐ No r) Any other Conditions, Diseases, Disorders or Injuries not listed above – Please specify _____

If you answered "Yes" to any of the conditions in question 3, please give details below

Name of person	Diagnosis	Date(s) diagnosed	Name of the Drug/Treatment	Date of last treatment or prescription filled

NOTE: If additional space is required, please attach a separate sheet.

Claims submitted are audited to verify accuracy of the medical information provided.

Part I
Physician & Dentist information

1. Have you, your spouse/partner or any listed dependent children consulted a **physician** annually over the last two (2) years?

Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No Dependent Children: ☐ 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 ( )

2. Have you, your spouse/partner or any listed dependent children visited a **dentist** on a regular basis over the last two (2) years?

Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No Dependent Children: ☐ Yes ☐ No

Provide the name and telephone number of your dentist. (If you do not have a dentist, indicate "None")

Name of Dentist Telephone Number ( )

3. Do you, your spouse/partner or any listed dependent children plan to visit a **dentist** in the next two (2) months?

Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No Dependent Children: ☐ Yes ☐ No

If "Yes", please indicate dental work to be done _____

NOTE: If the proposed dental work is expected to exceed $300 a detailed treatment plan is required from your dentist before your treatment begins.

Part J
Authorization to be signed by applicant and spouse/partner (if applicable)

NOTE: 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 my 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 inform Special Benefits Insurance Services Agency Inc. of a change in my health and that of my spouse/partner and any listed dependent children due to either injury or illness which occurs after the date of application and prior to the effective date of the policy.

I/We understand that the coverage shall not become effective until the first of the month following approval by Special Benefits Insurance Services Agency Inc. and/or Green Shield Canada. 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, and that of my spouse/partner and any listed dependent children, to exchange any such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Special Benefits Insurance Services Agency Inc. and/or Green Shield Canada. A reproduction of this consent and authorization shall be as valid as the original.

Signature of Applicant ✘ Date MM DD YYYY

Signature of Spouse/Partner ✘ Date MM DD YYYY

Additional medical information may be required to underwrite your application.

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

SPECIAL BENEFITS INSURANCE SERVICES

Providing marketing and administration for Prism® Health and Dental Programs

Make cheque payable to Green Shield Canada.
Mail ***completed*** application and cheques to:
Special Benefits Insurance Services
366 Bay Street, 7th Floor, Toronto, ON M5H 4B2

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