Application

Prism Precision® and Prism Continuum®

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 PRECISION®**
☐ P1 ☐ P2 ☐ P3 ☐ P4
☐ Yes. Please include Hospital Accommodation **(Approval and Additional premium required)**

PRISM CONTINUUM® (You must be leaving a Company Group Health Plan to be eligible for this program)
☐ C1 ☐ C2 ☐ C3 ☐ C4

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
Hospitalization statement

1 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 this question, please give details below

Name of person	Anticipated date of stay	Anticipated number of days in hospital	Details of illness or injury

Claims submitted are audited to verify accuracy of the medical information provided (Prism Precision® with Hospital Accommodation only)

Part H
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 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

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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