gsc healthassist®

LINK

Please complete SECTIONS A,B,C, D and E.

Application for **LINK** Health Coverage

Green Shield Canada (GSC)

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*

A: Are you covered, or were you covered under a group health plan? ☐ **Yes** ☐ **No**

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

C: Name of insurance carrier:

.....

Select one plan option:

- ☐ **LINK 1**
- ☐ **LINK 2**
- ☐ **LINK 3**
- ☐ **LINK 4**

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.

Please proceed to complete SECTIONS D and E.

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:	

gsc green shield canada

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

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

SECTION D — Payment Information

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.

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.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 E — 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, 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 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, to provide access to other GSC services, and/or to confirm the accuracy of the information with GSC. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and understand that information may be shared with my Advisor of record for the purposes previously identified.
A reproduction of this consent and authorization shall be as valid as the original.

X **Signature(s) Required:**

Signature of 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:	Advisor Signature:

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