



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

# Application for LINK Health Coverage Green Shield Canada (GSC)

SECTION A — Conta	ct Information							
Last Name:		First Name:		I	nitial:			
Street Address:			Apt. No:					
City/Town:	Province:	Province: F			ostal Code:			
Home Tel: ( )	Business Tel: ( )			(	Cell: ( )			
*Email Address (so GSC can conta	act you quickly about your appli	cation and benefits):						
SECTION B — Cover	age Information							
I declare that I, and my spouse	p/partner and all listed dep	endents are covered by o	ur provi	incial government l	nealth plan.			
I/We are applying for:	Select one plan option:							
Single coverage Applies to a	☐ LINK 1							
☐ Couple coverage Applies to a☐ Family coverage Applies to a☐				der age 21				
					⊔ LINK 2	☐ LINK 2		
A: Are you covered, or were y	ou covered under a group	health plan? 🗌 Yes 🗌 N	0		☐ LINK 3			
B: When does or did your cov	erage end? (YYYY/MM/DD):				□ LINK 4			
C: Name of insurance carrier:					Total Monthly Rate:			
					\$			
SECTION C — Individ	duals to be Covere	ed — please comple	ete in	full for FAC	H person			
Last Name	First Name			Gender	Date of Birth (YYYY/MM/DD)	Age		
Applicant:				☐ Male ☐ Female				
Spouse/Partner:				☐ Male ☐ Female				
Dependent Child: (must be unde	er age 21)			☐ Male ☐ Female				
Dependent Child: (must be unde	er age 21)			☐ Male ☐ Female				
Dependent Child: (must be unde	er age 21)			☐ Male ☐ Female				
Dependent Child: (must be unde	er age 21)			☐ Male ☐ Female				
<b>Note:</b> If additional space is rec	uired, please attach a sepa	arate signed and dated she	et.					
Please proceed to complete SEG	CTIONS D and E.							
FOR ADVISOR USE ONLY								
Advisor Code:	Advisor Name (first and last):	Advisor Email A	Advisor Email Address:					
Ott. C I								
Office Code:	Office Name:			Advisor Telepho				



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

### SECTION D — 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.

Pre-authorized Credit Ca	<b>rment</b> ard □ Mas	stercard	□Visa	☐ American Expres	S			
Name (as it appears on card):		Credit Card Number:					Expiry:	
Address:		City/To	wn:	Prov	vince:		Postal Code:	
Pre-authorized Debit F	PLEASE ATTACH A SPEC	IMEN CHEQUE	MARKED "VOID"					
Is this account Personal or	r Business? $\square$ Perso	nal 🗌 Busine	ess					
Is this a joint account? $\Box$	Yes 🗌 No	If "Ye	es", does this jo	int account require more th	nan one s	signature? 🗌 Ye	es 🗆 No	
If two signatures are requi	ired, information for	both Account	t Holders must l	oe provided:				
1st Account Holder				2 <sup>nd</sup> Account Holder				
Name:				Name:				
Address:				Address (if different from 1 <sup>st</sup>	payor):			
City/Town:	Province:	Postal	Code:	City/Town:		Province:	Postal Code:	
Telephone Number: (	)			Telephone Number: (	)			
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#### 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