

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 GreenShield Insurance 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 <i>Applies to applicant only</i> Couple coverage <i>Applies to applicant and spouse/partner OR applicant and one dependent child under age 21</i> Family coverage <i>Applies to applicant and spouse/partner and dependent children under age 21</i>	Select one plan option: LINK 1 LINK 2 LINK 3 LINK 4
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:	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: <i>(must be under age 21)</i>			Male Female		
Dependent Child: <i>(must be under age 21)</i>			Male Female		
Dependent Child: <i>(must be under age 21)</i>			Male Female		
Dependent Child: <i>(must be under age 21)</i>			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:	
MGA Code:	MGA Name:	Advisor Telephone Number:

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.

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:

1 st Account Holder	2 nd Account Holder				
Name:	Name:				
Address:	Address (if different from 1 st 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 GreenShield Insurance 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, GreenShield Insurance will give the applicant written notice at least thirty days prior to the change. GreenShield Insurance 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 GreenShield Insurance 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 GreenShield Insurance 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 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 GreenShield Insurance services, and/or to confirm the accuracy of the information with GreenShield Insurance. I/We acknowledge that all information provided to GreenShield Insurance 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 GreenShield Insurance service providers that require this information to perform their services, as is reasonably necessary, for the purposes identified above. Additional information on GreenShield Insurance 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 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:
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Please send applications to GreenShield Insurance, Individual Products Team, 5140 Yonge St., Suite 2100, Toronto, ON M2N 6L7