Application

PRISM PRECISION®

For Office Use Only

Badge Number	Source/Agent I.D. Number
Effective Date	**GS I.D. Number**
Approved by:	

SECTION A Coverage Information (Please print clearly or type)

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

I/We apply for ◯ Single coverage ◯ Couple coverage ◯ Family coverage

I/We apply for the following **PRISM PRECISION®** plan: ◯ **P1** ◯ **P2** ◯ **P3** ◯ **P4**

☐ **YES**. Please include Hospital Accommodation (Approval and additional premium required)

Are you covered, or were you covered under any other health plan? ◯ **YES** ◯ **NO**

If yes, please indicate if coverage was: ◯ Group ◯ Individual

When does/did your coverage end? (MM/DD/YYYY) _____

Name of insurance carrier: _____

ID# _____ Previous Employer's Name: _____

SECTION B Individuals to be Covered (Please print clearly or type)

NOTE: **Dependent children must be under age 21 to qualify for coverage.**

Last Name	First Name	Middle Initial		Gender M/F	Date of Birth (MM/DD/YYYY)	Age
Applicant			E			
Spouse/ Partner			S			
Dependent Child			C			
Dependent Child			C			
Dependent Child			C			

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

SECTION C Mailing Information (Please print clearly or type)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt. No: _____

City/Town: _____ Prov. _____ Postal Code: _____

Home Phone: _____ Business: _____ Cell: _____

Email: _____

If additional information is required, how may we contact you during our regular business hours? (Monday to Friday, 8:45 am to 4:45 pm ET)

☐ Home Telephone ☐ Business Telephone ☐ Mail (Canada Post) ☐ Email

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

SECTION D Statement of Health (Please print clearly or type)

NOTE: It is important that you answer all three (3) of the following questions:

1. Have you, your spouse/partner and/or any listed dependent children been hospitalized in the last two (2) years? ◯ **YES** ◯ **NO**

2. Do you, your spouse/partner or any listed dependent children expect to be hospitalized in the next six (6) months? ◯ **YES** ◯ **NO**

3. Are you, your spouse/partner or any listed dependent children pregnant? ◯ **YES** ◯ **NO**

If you answered "YES" to any of the above questions please provide details below:

First name of person	Date of illness, injury or confinement	Number of days in hospital	Details of illness or injury	Diagnosis/Follow-ups

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

SECTION E Dental Information (Please print clearly or type)

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

SECTION F Payment Information (Please print clearly or type)

Payment for the first two (2) months of coverage is due on your coverage effective date. All future payments will be made thirty (30) days in advance of the month for which coverage is to be provided.

Is this a personal or business account?: ◯ Personal ◯ Business

Is this a joint account? If "**YES**" does this joint account require two (2) signatures ◯ **YES** ◯ **NO**

If two (2) signatures are required please provide information for both account holders

1st Account Holder Name:

Address:

City/Town: Prov.: Postal Code:

Telephone Number:

2nd Account Holder Name:

Address:

City/Town: Prov.: Postal Code:

Telephone Number:

IMPORTANT: Applications cannot be processed without a "Void" cheque or a PAD form from your bank.
NOTE: We cannot accept line of credit or credit card cheques for pre-authorized payments.

I/We hereby authorize Green Shield Canada to withdraw the initial two (2) months' premium from my/our Financial Services Account (Pre-Authorized Debit). Payment for the first two (2) months of coverage is due on the coverage effective date. **Subsequent payments will be made thirty (30) days in advance of the month for which coverage is to be provided.**

I/We hereby authorize Green Shield Canada **to withdraw premium payments from my/our account specified on the attached void cheque or PAD form thirty (30) days in advance of the due date**, on or about the first (1st) 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 (required) ✘ Date MM DD YYYY

Signature of Second Account Holder (if applicable) ✘ Date MM DD YYYY

SECTION G Declarations and Authorizations

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 dependant 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 dependant 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 (1st) 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

SPECIAL BENEFITS INSURANCE SERVICES

Providing marketing and administration for Prism® Health and Dental Programs

Email ***completed*** application and void cheque/PAD form to: **general@sbis.ca**
Mail ***completed*** application and void cheque/PAD form to:

ADVISORS 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):	Code:	Advisor signature: