

APPLICATION FOR INSURANCE

Coverage available to applicants and their spouse from ages 18 to 64. Dependent children are covered up to age 21, or 25 if enrolled as a student full-time.

SECTION 1 - GENERAL INFORMATION (please print clearly)

Please complete this section for APPLICANT ONLY, spouse information should be listed under dependents

APPLICANT NAME First _____ Last _____ DATE OF BIRTH _____ YYYY/MM/DD AGE _____ Male Female

ADDRESS Street _____ Suite/Apt. _____ City/Town _____ Prov. _____ Postal Code _____

TELEPHONE: _____ EMAIL _____

SECTION 2 - COVERAGE BEING APPLIED

Benefit Applied for: BASE PLAN DELUXE PLAN Health Only Health & Dental Single Couple Family

If Applicant currently holds any other coverages offered through The Edge Plans (Policy No. _____) or is applying for any other Edge Plans at the time of this Health & Dental application you may use Edge Discounted Premium Rates.

Monthly Premium \$ _____

(A cheque for the initial premium must be submitted with this application)

DEPENDANT INFORMATION

If listing a dependent between the ages of 21 - 25, please attach proof of full-time student enrollment.

Name	Relationship to Applicant	Gender (M/ F)	Date of Birth (yyyy/mm/dd)

SECTION 3 - MEDICATIONS (Please Print Clearly)

Please list all medications you, your spouse/partner or any listed dependent children have taken in the last 3 months, including those for which refills are currently authorized or any medications expected to be used in the near future. If additional space is required, please attach a separate sheet.

Note: Prescription drugs include oral medications, injectables, creams, drops or serum.

Patient Name	Medication	Dosage	Frequency	Monthly Cost	Nature of illness/injury or condition
EXAMPLE: John Smith	Adalat xl	30 mg 1 tab	2 X/day	\$50.00	Hypertension

How long is medication expected to be taken? (indicate for each medication) _____

SECTION 4 - PRE-AUTHORIZED CHEQUING (PAC) PLEASE ATTACH A VOID CHEQUE.

I hereby request/authorize The Edge Benefits Inc. ("the Administrator") to debit my account, shown on the attached VOID cheque, pursuant to the Pre-Authorized Chequing Agreement outlined on the attached product overview, for each month's premium payable to the Administrator and its successors or assigns. The Administrator's treatment of each payment shall be as if it were a cheque drawn on my account, and signed personally by me. Under this premium payment method, the Administrator shall not be required to give notice of premiums due. The expression "cheque" used in this request includes magnetic or computer produced paper tape that is or purports to be a direction to credit any amount to the Administrator and debits such amount to the account described. If a pre-authorized cheque is returned due to non-sufficient funds, the Administrator is authorized to redeposit the cheque or add the appropriate amount to the next cheque. A \$25.00 service fee will be applied to all NSF cheques.

Premiums will be withdrawn on the 1st of each month.

Name of Bank: _____ **Transit #:** _____ **Institution #:** _____ **Account #:** _____

Date: _____ **Signature** (as it appears on bank records) _____

Date: _____ **Second Signature** (if required for joint account) _____

SECTION 5 - AGREEMENT AND DECLARATION

- 1) I declare that I, my spouse/partner and all listed dependents have provincial health care coverage.
- 2) I 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 and that Green Shield Canada and The Edge Benefits Inc. reserve the right to validate the answers to the questions in this application.
- 3) I understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and or listed dependents could result in denial of a claim and the cancellation or modification of the coverage.
- 4) I am authorized to release information concerning my spouse/partner and my dependent child(ren) for the purposes of determining their eligibility for benefits.
- 5) I hereby authorize any licensed physician, or other medical practitioner, medical or medically related facility, that has any records or knowledge of me or my health, or that of my spouse/partner or any listed dependents, to exchange any such information as is needed to administer benefit claims and/or confirm the accuracy of the information with The Edge Benefits Inc. and/or Green Shield Canada. I may request and receive a copy of any medical information obtained with this authorization. A photographic copy of this authorization shall be as valid as the original.
- 6) I hereby understand that the coverage applied for shall be effective on the 1st of the month following notification of approval. I understand that it is my obligation to inform The Edge Benefits Inc. of a change in my health or that of my listed dependents due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.
- 7) I declare that I am able to read and/or speak English or French and acknowledge having read this notice.

Signed at: _____ **Date (yyyy/mm/dd)** _____

Signature of applicant: _____

Notice of Disclosure from Agent or Broker to the Applicant. I declare that I am remunerated by commissions from The Edge Benefits Inc. depending upon volume of sales I may qualify for bonuses, awards and/or trips.

Green Shield Canada reserves the right to perform a claim audit from time to time to verify the accuracy of the medical information provided.

Note, this plan is medically underwritten. Pre-existing conditions may affect your eligibility for coverage or the type of coverage offered by Green Shield Canada.

SECTION 6 - PRODUCER INFORMATION

Producer's Signature _____

Print Name Brian Rose **Telephone No.** (780) 441-4792



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The Edge Health & Dental Benefits are provided by Green Shield Canada