Application

Prism Precision™ and Prism Continuum™

For Office Use Only		
Badge Number	Approved By	Source/Agent I.D. Number 2437
Effective Date	Billing Division Number	GS I.D. Number

Part A
Plan Selection

1. I/We Apply For ❑ Single ❑ Couple ❑ Family
2. Do you, your spouse/partner and all listed dependents have Provincial Government Health Care coverage? ❑Yes ❑No
   NOTE: If you answered "NO", refer to the enclosed "General Information" booklet under FAQ's, Application/Enrollment Information.
3. **PRISM PRECISION™**
   ❑ P1 ❑ P2 ❑ P3
   ❑ Yes. Please include the Semi-Private Hospital Accommodation **(Additional premium required)**

   PRISM CONTINUUM™ (You must be leaving a Company Group Health Plan to be eligible for this program)
   ❑ C1 ❑ C2 ❑ C3

Part B
Individuals to be covered

Please print clearly

Dependent children must be under age 21

All 3 sections must be completed for the Applicant, Spouse/Partner and Dependent Children

1 Provide the Last Name of any family member if different from the applicant	2 Provide the First Name and Initial or all family members to be covered		3		Birth Date			
Last Name	First Name	Initial	Code	Sex	Year	Month	Day	Age
Applicant			E					
Spouse/Partner			S					
Dependent Child			C					
Dependent Child			C					
Dependent Child			C					

Part C
Mailing address

Last Name First Name Initial

Apt. No Street Address

City or Town Prov. Postal Code

Home Telephone ( ) Business Telephone ( )

E-mail Address

If additional information is required, how may we contact you during our regular business hours?
❑ Home Telephone ❑ Business Telephone ❑ Mail (Canada Post) ❑ E-mail Address

Status ❑ Single ❑ Couple ❑ Family ❑ Other ________ Applicant's Occupation:

Part D
Other coverage

1. Are you covered, or were you covered by an **Individual Health Plan?** ❑ Yes ❑ No
   If "YES", when does/did your Individual Health Plan end? MM DD YYYY
   Name of Insurance Company
2. Are you covered, or were you covered by a **Group Health Plan** within the last 60 days? ❑ Yes ❑ No
   If "YES", when does/did your Group Health Plan end? MM DD YYYY
   Name of Insurance Company
   ID# Previous Employer's Name

Part E
Account/ Banking Information

1. Is this a joint account? ❑ Yes ❑ No

   If "YES", does this joint account require only one signature? ❑ Yes ❑ No

2. Name of account holder(s)/company if different from applicant: ____________

   Address of account holder(s)/company if different from applicant: ____________

Initial payment

Important: First Bank Withdrawal – Refer to the enclosed General Information Booklet for banking information regarding your first bank withdrawal.

Please make cheque payable to: "Green Shield Canada"

Applications cannot be processed without the first two months payment plus one of the account holder's cheques marked "Void"

Part F
Pre-authorized payment

I/We hereby authorize Green Shield Canada **to withdraw premium payments from my/our account thirty (30) days in advance of the due date**, on or about the first 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. 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 is received by Green Shield Canada, ten (10) business days prior to the next pre-authorized debit due date** requesting cancellation by either the applicant or account holder(s).

Signature of Account Holder ✘ ____________ Date ____________
MM DD YYYY

2nd Signature if Joint Account ✘ ____________ Date ____________
MM DD YYYY

Part G
Hospitalization Statement

1. Do you, your spouse/partner and/or any listed dependent children expect to be hospitalized in the next six months?

   Applicant: ❑ Yes ❑ No Spouse/Partner: ❑ Yes ❑ No Dependent Children: ❑ Yes ❑ No

If you answered "YES" to this question, please give details below

Name of Person	Date of Illness Injury or Confinement	Number of days in hospital or anticipated number of days in hospital	Details of Illness or Injury

Claims submitted are audited to verify accuracy of the medical information provided (Prism Precision™ with Semi-Private Hospital Accommodation only)

Part H
Authorization to be signed by applicant and spouse/ partner (If applicable)

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 dependent children, for the purposes of determining their eligibility for benefits.

I/We understand that the coverage shall not become effective until the first 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, or that of my spouse/partner or any listed dependents, 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

Green Shield Canada's commitment to privacy

Your personal information is collected for the purpose of providing you with health and dental benefits, claims analysis and payments. For information on Green Shield Canada's privacy policies and procedures visit www.greenshield.ca

GREEN SHIELD CANADA

Marketed by:

The exclusive Managing General Agent (MGA) for the Prism™ Health and Dental Benefit Programs for Individuals.

Mail ***completed*** application and cheques to:
Smartterm.ca
226-3365 Harvester Rd
Burlington, Ontario L7N 3N2
Attn: Lewis Weinerman