APPLICATION FOR MYCARE ADVANTAGE INSURANCE COVERAGE

Name of Broker (if any): _____

Name of Third Party Administrator (TPA): _____

EMPLOYER INFORMATON

Company Name (if applicable): .....

EMPLOYEE INFORMATION

Applicant's Full Name First: ..... Last: ..... Initial(s): .....

Date of Birth (MM/DD/YY) ..... ☐ **Male** ☐ **Female** **Provincial Health Plan Coverage?** ☐ **Yes** ☐ **No**

Mailing Address .....

City ..... **Province** ..... **Postal Code** .....

Phone Day: ..... Evening: ..... **Email** .....

COVERAGE SELECTION

Coverage Type: ☐ Single ☐ Couple (defined as two adults OR one adult and one dependent) ☐ Family

Smoking Status of Applicant: ☐ Smoker ☐ Non Smoker
Non-smoker rates apply to applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the last 12 months.

Premium amount quoted: $.....

ADDITIONAL INDIVIDUALS TO BE COVERED

If applying for Couple or Family coverage, please complete the following information for your eligible Spouse and/or Dependent Children. Attach separate sheet if additional space is required.

First Name	Surname	Gender	Date of Birth *(MM/DD/YY)*	Relationship to Applicant	Smoking Status	Provincial Health Plan Coverage?
					☐ Smoker ☐ Non Smoker	☐ Yes ☐ No
					☐ Smoker ☐ Non Smoker	☐ Yes ☐ No
					☐ Smoker ☐ Non Smoker	☐ Yes ☐ No
					☐ Smoker ☐ Non Smoker	☐ Yes ☐ No

If your Dependent Child is age 19 or over, please complete the following information to confirm their eligibility:

MyCare/GBA requires annual confirmation of eligibility for all over-age dependents insured. To ensure accurate claims payments, a Request for Overage Dependent. Coverage Form must be completed upon enrolment or as deemed necessary. If applicable, visit www.mycare.ca or contact MyCare Administration & Client Services at 1-877-497-9495 or apply@mycare.ca

Name of Student	Student Status	Name & Address of Accredited Post Secondary Institute
	Full Time? ☐ Yes ☐ No	
	Full Time? ☐ Yes ☐ No	

Pre-Existing Condition under the MyCare program means: 1. A condition for which an Insured Person is given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation **prior** to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage; or 2. A condition which produced symptoms prior to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage. These symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests: a) The symptoms would allow one learned in medicine to make a diagnosis of the disorder; or b) The symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment.

AUTHORIZATION

I hereby authorize the employer's Third Party Administrator (TPA) and MyCare's approved administrator, Global Benefits Advisors Ltd. (GBA), or its representative(s) and Insurers of the MyCare program to release all medical information including but not limited to all diagnostic and treatment reports, test results and treatment recommendations to my family physician and/or attending Canadian physician(s). I also authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsurance company, government health insurance plan or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named minor children and other non-medical information of me or my named minor children, to give to GBA or its legal representative any and all such information. Any information obtained will not be released by MyCare/GBA to any person or organization except to insuring or reinsuring companies or other persons or organizations performing business or legal services in connection with my enrolment for the insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that if I decide to add a newborn, foster, step or adopted child for immediate coverage under MyCare and such enrolment is not made within thirty-one (31) days from the date of birth or adoption, or within thirty one (31) days from the date I become legally responsible for a step or foster child, I will be required to submit an application (including evidence of insurability) satisfactory to MyCare/GBA before the insurance is effective. In this case, my dependent Child's insurance is not effective until the date MyCare/GBA specifies. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this signed authorization shall be valid as long as any claim under the Policy is outstanding.

PRIVACY AND CONFIDENTIALITY: MyCare/GBA recognizes and respects every individual's right to privacy. When you apply for coverage or submit a claim, we establish a confidential file of personal information. We use the information to administer the individual benefit plan under which you are covered. MyCare/GBA limits access to confidential information to MyCare/GBA staff or persons authorized by MyCare/GBA, the underwriters who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. MyCare/GBA, your health care provider or other insurance and reinsurance companies may also exchange information when the information is needed to administer your MyCare program.

I confirm:

i) I have read and understand the **Pre-Existing Condition Limitation** contained in this application.
ii) I understand that MyCare coverage is conditional upon acceptance of my Application by MyCare/GBA and will become effective in accordance with the Policy.
iii) I have read the above notice on **Privacy and Confidentiality** and consent to the collection, use and disclosure of my personal information (including personal information about my dependent(s)) required for enrolment and ongoing administration of the plan.
iv) **If I have applied for Non-Smoker rates**, I confirm that I have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc.) within the last 12 months.

I hereby understand that this policy will not come into effect until such time as MyCare/Global Benefits Advisors has confirmed and communicated coverage to the insured or the duly authorized representative of the insured. Furthermore all appropriate premium for the coverage selected has been received.

Applicant Signature **(must always sign)**	Applicant Name (print)	Date Signed (MM/DD/YY)
Spouse's Signature	Spouse's Name (print)	Date Signed (MM/DD/YY)
Dependent's Signature (if 19 or over)	Dependent's Name (print)	Date Signed (MM/DD/YY)
Dependent's Signature (if 19 or over)	Dependent's Name (print)	Date Signed (MM/DD/YY)

Authorized Signature: _____

Name: _____

Dated (MM/DD/YYYY): _____

Please send your completed application to us:

Email: apply@mycare.ca
Fax: 1-877-247-9891
Mail: MyCare Advantage Processing: PO BOx 36045, Lakeview RPO, Calgary, AB, T3E 7C6