APPLICATION FOR INDIVIDUALS

Name of Broker (if any): ____________________________________

APPLICANT 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** ____________

If Billing Name &/or Address differs from Applicant above, complete the following:

Bill To Name (First/Last or Company Name) ____________

Billing 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 LIMITATION

A 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 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.

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)

PREMIUM PAYMENT OPTIONS: Premium subject to Provincial Sales Tax, where applicable

Option 1 ☐ Cheque   Option 2 ☐ Wire Transfer   Option 3 ☐ Pre-Authorized Debit (PAD)

Frequency of Payment: ☐ Annual ☐ Monthly

CHEQUE: Make cheques payable to Global Benefits Advisors Ltd. For monthly payments attach a cheque for the first month's premium, you will be billed for the balance once coverage is approved.
PAD (Pre-Authorized Debit): Complete the attached PAD Agreement.
WIRE TRANSFER: Banking transfer details will be provided to you upon receipt of this application form.

Please send your completed application to us:

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

MyCare

www.mycare.ca

Pre-Authorized Debit (PAD) Agreement

I hereby authorize Esorse Corporation, on behalf of MyCare, herein referred to as "**Esorse**", to make automatic withdrawals for my premiums, from my account at the financial institution named below.

I understand that premiums will be withdrawn on approximatley the 20th of each month.

Furthermore, I understand that Esorse may terminate my Pre-Authorized Debit plan if any withdrawal is reversed by my financial institution. Esorse is also authorized to charge a fee for any pre-authorized debits not honored by my financial institution.

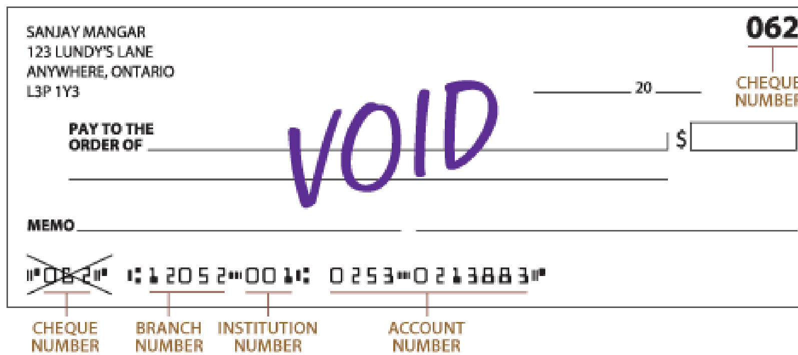
This agreement will remain in effect until Esorse receives a written notice of cancellation from me at least ten (10) business days prior to the next scheduled withdrawal.

I understand that I have the right to receive reimbursement for any unauthorized PAD or any withdrawal not consistent with this agreement.

Account Information

Branch number : ______ Institution number: ______ Account number: ___________________

Cheque sample:



If you are unsure of your banking information, then please attach a void cheque.

Your void cheque MUST contain your institution's address.

Authorization

Printed Name: ____

Signature: _______________________________________ Date: __________________________

Esorse: 385 Traders Blvd., Missassauga, ON, L4Z 2E5 | Toll-Free: (877) 6-ESORSE | FAX: (647) 288-0447
info@esorse.com

MyCare: PO Box 36045, Lakeview RPO, Calgary, AB, T3E 7C6 | Toll-Free: (877) 497-9495 | info@mycare.ca