

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** **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

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

Please print clearly

Dependent children must be under age 21

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 **X** _____ Date _____
MM DD YYYY

2nd Signature if Joint Account **X** _____ 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 **X** _____ Date _____
MM DD YYYY

Signature of Spouse/Partner **X** _____ 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



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

REV: 08/07