belairdirect.
group benefits

belairdirect Personal Health Plan Application Form
for individual health and dental coverage

For belairdirect use only:			
Plan Sponsor Name:	**Plan Sponsor ID Number:**	**Billing Division**	**GSC ID Number: JAC**

The plan is administered by belairdirect. Claims and risk are managed by Green Shield Canada.

Please print and complete this form in full

Section A: Application Information

First name	Initials	Last name	
Address (street/apt)			Gender ☐ Female ☐ Male
City	Province	Postal Code	
Date of birth (dd/mm/yyyy)	Provincial/Territorial Health Insurance Card #		
Daytime telephone #	Email address		
Name of employer/association			

Section B: Coverage Information

1. I declare that I, my spouse/partner and all listed dependents, have provincial or territorial health care coverage.

2. a) I/We are applying for: ☐ Single coverage ☐ Couple coverage ☐ Family coverage
   b) I/We are selecting: ☐ Optimum plan (health, prescription drugs, and dental)
   ☐ Preferred plan (health and prescription drugs, no dental)
   ☐ Standard plan (health and dental, no prescription drugs)

3. Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No
   If yes, please indicate if coverage was a/an ☐ Group health plan ☐ Individual health plan

   When did/does your coverage end (dd/mm/yyyy): _____

   Name of insurance company: _____

Section C: Spouse/Partner and Dependent Information

First name	Last name	Provincial or territorial health card #	Gender M/F	Date of birth (dd/mm/yyyy)	Student ages 21-25 Y/N	Disabled Y/N
spouse/partner					n/a	
dependent						
spouse/partner						

If additional space is required, please attach a separate sheet, signed and dated.

Section D: Statement of Health and Prescription Drug Information

Complete section D if you are applying for the optimum plan or preferred plan.
If you are applying for the standard plan, proceed to section E

Green Shield Canada reserves the right to perform claim audits from time to time to verify the accuracy of the health information provided.

1. Have you, your spouse/partner and/or any listed dependent been hospitalized in the last two (2) years?

Applicant	Spouse/Partner	Dependent
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Do you, your spouse/partner and/or any listed dependent expect to be hospitalized in the next six (6) months?

Applicant	Spouse/Partner	Dependent
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to Questions 1 or 2, please provide details below:

First name of person	Date of illness, injury or confinement	Actual/anticipated # of days in hospital	Details/Outcome of injury or illness

3. Have you, your spouse/partner and/or any listed dependent ever been treated for, consulted or received advice from a physician or specialist or had any indication of any of the following conditions? Check Yes or No for all questions.

Medical condition	Applicant	Spouse/Partner (if applicable)	Dependent (if applicable)
a) anxiety, depression, insomnia, ADD/ADHD, eating disorders or any other emotional, mood, behavioral or mental health disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
b) Alzheimer's disease, dementia, Parkinson's disease, seizures / epilepsy, loss of consciousness, multiple sclerosis, paralysis or any other neurological disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
c) kidney stones, kidney disease, interstitial cystitis, benign prostatic hyperplasia (BPH) or any other kidney, bladder and prostate disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
d) liver disorders, including hepatitis	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
e) infertility, ovarian cyst, PCOS, uterine fibroids, irregular menses, menopause or any other reproductive or breast disorder	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
f) Crohn's disease, ulcerative colitis, irritable bowel syndrome, ulcer, hernia, persistent heartburn / reflux or any other gastrointestinal disorder	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
g) disease, stroke/ TIA (mini-stroke), heart attack, irregular heartbeat, angina, high blood pressure, elevated cholesterol or any other circulatory, heart or vascular disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
h) alcoholism or drug dependency	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
i) skin disorders, including acne	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
j) HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
k) arthritis, osteoporosis / osteopenia, back pain, joint pain, muscle pain, fibromyalgia or any other joint, bone, or muscular disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
l) allergies, asthma, COPD, chronic bronchitis, emphysema, or any other respiratory or lung disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

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m) chronic headaches or migraines	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
n) basal cell carcinoma, growths, polyps, tumors, leukemia or any other cancers	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
o) cold sores, herpes or any other sexually transmitted diseases or infections (STDs or STIs)	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
p) diabetes/elevated glucose, hypothyroidism, hyperthyroidism, adrenal fatigue or any other endocrine, hormonal or thyroid disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
q) glaucoma, cataracts, Meniere's disease or any other eye, ear, or balance disorders	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
r) any other condition, disease, disorder, or injury not listed above: _____	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

If you answered "yes" to any of the conditions in question 3, please provide details below:

Question letter	First name of person	Nature of illness, injury or condition	Date of first visit/treatment	Date of last visit/treatment	Drugs / treatment	Result of last consult / current status

4. Do you, your spouse/partner and/or any listed dependent currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? Prescription drugs include oral medication, injectables, creams, drops or serum.

Applicant	Spouse/Partner	Dependent
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

First name of person	Name of drug/medication/serum/cream	Strength and daily dose of the drug/medication/serum/cream	Daily dosage of the drug/medication/	Length of time on this drug/medication/	Number of refills per year

5. Have you, your spouse/partner and/or any listed dependents consulted a physician annually over the last two (2) years?

Applicant	Spouse/Partner	Dependent
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Provide the name and telephone number of the physician who holds the majority of your health records.
If you do not have a doctor, indicate "none".
Name of Physician/Medical Clinic: _____ Telephone #: _____

belairdirect'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 more information on belairdirect's privacy policies and procedures, visit belairdirect.com.

If additional space is required, please attach a separate sheet, signed and dated.

Section E – Declarations and Authorizations (please read and sign below)

Completed applications are to be mailed to belairdirect along with a blank cheque marked "VOID". Please ensure all sections are completed or the application will be returned to you.

Privacy
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Declarations

1. I (the applicant) hereby apply for benefit coverage with Green Shield Canada.
2. I am authorized to release information concerning my spouse/partner and/or dependent, for the purposes of determining their eligibility for benefits.
3. By signing this application form, I/we declare the statements contained in this application, including but not limited to the Statement of Health, are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any Contract issued hereunder.
4. I/We understand any health information must be accurate as at the date the application is signed. Any misrepresentation, including misstatement shall render the benefit coverage voidable at the discretion of Green Shield Canada.
5. I/We understand that it is my/our obligation to notify belairdirect Agency Inc. of a change in the health of anyone listed in Section C due to either injury or illness which occurs after the date of application and prior to the effective date of coverage.
6. I/We understand there are exclusions and limitations on the coverage applied for.
7. I/We understand based on the health information provided, coverage may be declined or modified to exclude certain medical conditions.
8. 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 such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Green Shield Canada.
9. By applying for coverage I/we understand my/our information may be used to confirm sponsored group membership and eligibility under this Plan.
10. I/We understand coverage will take effect on the first of the month following the receipt of my/our properly completed application (including the Statement of Health) and approval by Green Shield Canada.
11. I/We hereby authorize belairdirect Agency Inc. to withdraw premium payments from my/our account thirty (30) days in advance of the due date, on or about the 5th day of each month.
12. I/We further authorize my/our premium for this benefit coverage, including any adjustments, arrears and renewals to be deducted in monthly amounts from my/our chequing account.
13. Should there be any change in either the amount or premium due date, belairdirect Agency Inc. will give the applicant written notice of at least thirty (30) days in advance.
14. I/We understand my/our coverage will be automatically terminated should belairdirect Agency Inc., the Plan Administrator, receive two or more Non-Sufficient Funds (NSF) notices on my/our account.
15. I/We understand coverage will automatically be renewed under the policy terms and conditions then in effect, unless I/we provide written notice of termination to the Plan Administrator within 60 days from the first premium deduction for the Policy Year.
16. I/We acknowledge that my/our Contract will contain a privacy statement outlining how my/our personal and other information may be collected, used and disclosed in connection with my/our coverage, claims thereunder and other stated purposes among belairdirect Agency Inc., Green Shield Canada, my/our sponsor group and any other applicable parties. For privacy information, please refer to belairdirect.ca or greenshield.ca.
17. A reproduction of this declaration and authorization shall be as valid as the original.

Authorization:
I authorize monthly deductions from my bank/trust/credit union account. Due to application processing time, and the effective date of coverage, the initial deduction may cover up to 3 months of premium. If more than one signature is required on cheques issued from a joint account, all depositors must sign below.

Signature of applicant	Date (dd/mm/yyyy)
Signature of spouse/partner (if applicable)	Date (dd/mm/yyyy)
Signature of joint account depositor (if applicable)	Date (dd/mm/yyyy)

☐ I/We have attached a blank personal cheque for my/our account and marked it **VOID**. Subject to Green Shield Canada's approval, I/we understand coverage will begin on the 1st of the month following the approval date of my/our completed application

Coverage provided by: Green Shield Canada
For more information, contact belairdirect at:

Telephone: 1 833 749.1324
Website: belairdirect.com
Mail: PO Box 4216 Stn A
Toronto, Ontario M5W 5M7

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