benecaid®

Member Application

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Select the Benefit Option that applies:

	Coverage	Price
	Individual Deluxe	$105/month
	Individual Basic	$95/month

	Coverage	Price
	Couple Deluxe	$155/month
	Couple Basic	$140/month

	Coverage	Price
	Family Deluxe	$200/month
	Family Basic	$180month

Completion of this Form is required for insurance coverage. If space is insufficient for any question, print the answer on additional paper, sign, date & attach to this form.

Member Information

Company Name ☐ Incorporated ☐ Not Incorporated

Last Name: First Name: Middle Initial:

Street Address: Unit #: PO Box:

City: Province: Postal Code:

E-mail Address: Home Telephone: Business Telephone:

Date of Birth: YYYY MM DD Height: Feet Inches Weight: lbs Gender: ☐ Male ☐ Female

Dependent Information

Relationship	First Name	Last Name	Date of Birth	Height (Feet & Inches)	Weight (lbs)	Gender M / F	Student Age 21-24	Disabled
Spouse			YYYY MM DD				N/A	N/A
Child			YYYY MM DD				☐ Yes ☐ No	☐ Yes ☐ No
Child			YYYY MM DD				☐ Yes ☐ No	☐ Yes ☐ No
Child			YYYY MM DD				☐ Yes ☐ No	☐ Yes ☐ No

Pre-Authorized Payment - Category: Business ***Please attach a VOID cheque***

Name of Designated Financial Institution

FI Code: (3 digits) Transit: (5 Digits) Account:

☐ **Select if you would like to use the above account information for Claims Reimbursement. If not, a Direct Deposit form must be completed and included.**

Medical Conditions

Have you or any of your dependents ever been diagnosed with; received medical treatment for; or consulted with a physician for any of the following?

Condition	No	Yes	Condition	No	Yes
Heart Chest Pain, Angina, Heart Attack, Arrhythmia, Murmur, Congestive Heart Failure, A trial fibrillation, Dizziness, Fainting			High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A (mini-stroke), Stroke, Aneurysm or Circulatory disorder		
Huntington's Chorea, Amyotrophic Lateral Sclerosis or Motor Neuron Disease			Digestive System Disorder or Liver Disease or Disorder Including Hepatitis, Kidney disorder?		
Diabetes, Diverticulitis, Colitis or Chrohn's			Skin Disorder (including Acne)		
Immune Disorders including testing for Immune Deficiency Syndrome (AIDS) or Human Immune Syndrome (HIV)			Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD or Emphysema		
Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic fatigue or Fibromyalgia			Nervous, Mental or Emotional Disorders, Alzheimer, Parkinson's, Memory Loss or Seizure Disorder?		
Cancer, Tumor or Growth (except Basal Cell Carcinomat)			Auto-Immune Disorders-Systemic Lupus Erythematosus (S.L.E) or Scleroderma		
Infertility or Reproductive Disorder, Menopause or Prostate Disorder			Alcoholism or Drug Abuse/Dependency		
Chronic Headaches, Migraines or recurrent infections			Other Condition/Disease/Disorder or Injury		

If you answered "Yes" to any of the conditions above, please provide the details below.

Name of Person	Condition	Date Diagnosed or Treated
		YYYY MM DD
		YYYY MM DD
		YYYY MM DD

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Member Application for Incorporations

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Member Name: ______________________ **Telephone:** ______________________

Hospitalization / Surgery

Have you or any of your Dependents been hospitalized or had any surgery in the past five (5) years? ☐ Yes ☐ No If "Yes", please complete the following.

Name of Person	Medical Condition	Surgery or Treatment	Date of Hospitalization or Surgery
			YYYY MM DD
			YYYY MM DD
			YYYY MM DD

Have you or your Dependents been advised to have any test, investigation or surgery which has no yet been completed? ☐ Yes ☐ No

If "Yes", please provide details: ______________________

Family Physician

Please complete the following physician information.

Name	Address	Telephone	Date of Last Visit
			YYYY MM DD
			YYYY MM DD

Any future visits scheduled with any medical professional for you or your Dependents? ☐ Yes ☐ No

If "Yes", what type of practitioner is to be seen? ______________________

Reason for the visit? ______________________ Expected date of future visit? ______________________

Declaration

☐ **Use of Your Information:** The insurance you are applying for, or have been provided with, is underwritten by an insurer (the "Insurer") and is administered by Benecaid Health Benefit Solutions Inc. ("Benecaid"). You agree that Benecaid and the Insurer may collect, use and disclose your information as described in the enclosed Privacy Agreement. You agree that you will only provide information about your spouse or your dependent children, if each of them have authorized you to do so, and if each of them have consented to the collection, use and disclosure of his or her information as described in the enclosed Privacy Agreement. **Declaration:** You declare that you are currently in good health and that the information provided above is complete and true to the best of your knowledge. You acknowledge that if at the time of claim it is discovered that any question in this Enrolment Form is not answered truthfully, accurately and completely, it will result in the non-payment of any claim and/or your coverage will be null and void. **Costs:** You understand that all costs, including the costs of doctors notes and fees, incurred by Benecaid or the Insurer to validate whether a condition is pre-existing in nature (a "Pre-Existing Condition"), will be your responsibility and will not be paid or reimbursed by Benecaid or the Insurer. You understand that a Pre-Existing Condition is any injury, disease, sickness, pregnancy or mental disorder for which you have, or an ordinarily prudent person would have: visited or consulted a physician, hospital or medical facility; taken clinical tests; or received treatments which include (but are not limited to) taking pills, injections or other medications to treat any condition. **Communication:** You consent to Benecaid communicating with you via email. **Copies:** You agree that a photocopy or electronic copy of this section is as valid as the original.

☐ I/We authorize Benecaid Health Benefit Solutions Inc., and the financial institution designated (or any other financial institution. I/we may authorize at any time) to begin deductions as per my/our instructions for regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Benecaid Health Spending Account. Regular payments for the full amount of services delivered will be deducted from my/our specified account on the 25th day of the month per my/our Health Spending Account contribution schedule. Benecaid Health Benefit Solutions Inc. will provide five (5) days written notice of the amount of regular debit. Benecaid Health Benefit Solutions Inc. will obtain my/our authorization for any other one-time or sporadic debits. This authority is to remain in effect until Benecaid Health Benefit Solutions Inc. has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAP Agreement at my/our financial institution by visiting www.cdnpay.ca. Benecaid Health Benefits Solutions Inc. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (10) days prior written notice to me/us. I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAP that is not authorized or is not consistent with this PAP agreement. To obtain a form for reimbursement claims, or for more information on my/our rights, I/we may contact my/our financial institution or visit
www.cdnpay.ca.

Signature of Employee: ______________________ Date: YYYY MM DD

Signature of Spouse:
(if coverage required) ______________________ Date: YYYY MM DD

Signature of Dependent Child(ren): ______________________ Date: YYYY MM DD

Submit your form and signed agreement to:

Benecaid Health Benefit Solutions Inc
Attn: Sales Department
Email: sales@benecaid.com or Fax: 1-877-797-7449

Member Name: ______________________________ **Telephone:** ______________________________

Privacy Agreement

In this Agreement, the words "you" and "your" mean any person who has requested from us, applied for, or is insured under any product or service offered, insured, reinsured, administered or sold by us. The words "we", "us" and "our" mean

(1) Benecaid Health Benefit Solutions Inc. and Benecaid Insurance Solutions Inc. (collectively "Benecaid") and any affiliates of Benecaid. (2) any insurance company that insures your personal accident, sickness, life, travel, dental or other coverage provided through Benecaid; (3) any company that will in future provide coverage that replaces all or part of the insurance coverage listed in (2) or any other insurance currently provided through Benecaid; (4) any company that provides reinsurance to any company listed in (1) through (3); and (5) service providers for any company listed in (1) through (4).

The word "Information" means personal, health-related, financial and other details about you that you provide to us and we obtain from others outside our organization, including through the products and services you use.

You acknowledge, authorize and agree as follows:

COLLECTING YOUR INFORMATION

At the time you begin a relationship with us and during the course of our relationship, we may collect Information directly by us, or through our representatives, including:

- details about you and your background, including your name, address, date of birth, occupation and other identification, all of which are required under law;
- information you provide through the application and claims process for any of our insurance products or services; and
- information for the provision of insurance products and services.

This Information may be collected from you and from sources outside our organization, including from:

- government agencies and registries, law enforcement authorities and public records;
- any healthcare professional, medically-related facility, insurance company, or other person who has knowledge of; your information
- other service providers, agents, brokers and other organizations with whom you make arrangements; other insurance companies;
- your employer; references you have provided; and
- persons authorized to act on your behalf under a power of attorney or other legal authority.

You authorize those sources to give us the Information.

USING YOUR PERSONAL INFORMATION

This information may be used for the following purposes:

- to administer your insurance and your trust accounts (if any); to communicate with you;
- to verify your identity and investigate your personal background; to investigate, adjudicate, manage and coordinate your claims;
- to arrange and maintain insurance products and other services you may request; to help us better manage our business and your relationship with us;
- to evaluate and underwrite insurance risk, re-price medical expenses and negotiate payment of claims expenses;
- to better understand your insurance situation; to offer you products and services to meet your needs; to determine your eligibility for insurance and non-insurance products and services we offer;
- to detect and prevent fraud;
- to compile statistics; to help us better understand the current and future needs of our clients; and
- as required or permitted by law.

DISCLOSING YOUR INFORMATION

We may disclose your Information, including as follows:

- to other insurance companies, other financial institutions and health organizations;
- to any health-care professional, medically-related facility, insurance company or other person who has knowledge of your personal Information; to appropriate public health authorities.
- to administrators, service providers, reinsurers and prospective insurers and reinsurers of our insurance operations, as well as their administrators and service providers for these purposes;
- in response to a court order, search warrant or other demand or request, which we believe to be valid;
- to meet requests for information from regulators, including self-regulatory organizations of which we are a member or participant, to satisfy legal and regulatory requirements applicable to us;
- to our employees, suppliers, agents and other organizations that perform services for you or for us or on our behalf;
- when we buy or sell all or part of our businesses or when considering such transactions;
- to help us collect a debt or enforce an obligation owed to us by you; and
- where permitted by law.

Telephone discussions – When speaking with one of our telephone service representatives, we may monitor and/or record your telephone discussions for our mutual protection, to enhance customer service and to confirm our discussions with you.

MORE INFORMATION

Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details regarding how your privacy is protected can be obtained by asking us for a copy of our Privacy Policy.

Please read our Privacy Policy for further details about this Agreement and our privacy policies. Visit www.benecaid.com or contact us for a copy.

You acknowledge that we may amend this Agreement and our Privacy Policy from time to time to reflect changes in legislation or other issues that may arise. We will post the revised Agreement and Privacy Policy on our website listed above. You acknowledge, authorize and agree to be bound by such amendments.

If you wish to opt-out or withdraw your consent at any time for any of the opt-out choices described in this Agreement, you may do so by contacting us at: **1-877-797-7449**. Please read our Privacy Policy for further details about your opt-out choices.