APPLICATION FOR MYCARE SURGICAL INSURANCE PROGRAM

Name of Broker (if any): _____

Name of Third-Party Administrator (TPA if any): _____

MAIN APPLICANT INFORMATON (FOR GROUP PLANS ONLY)

Company Name: .....

MAIN 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** .....

COVERAGE SELECTION

Coverage Type: ☐ **Single** ☐ **Couple** ☐ **Single Parent Family** ☐ **Family**

Applicants Occupation: ..... **Spouse Occupation** .....

Smoking Status of Applicant: ☐ **Smoker** ☐ **Nonsmoker**

Nonsmoker
An individual who has NOT smoked or vaped, or used any form of tobacco, nicotine or cannabis product, in the last 12 months. Including, but not limited to cigarettes, cigars, cigarillos, pipe, cannabis (including medical cannabis, recreational cannabis whether smoked, vaped or used in any digestible format), snuff, chewing tobacco or nicotine products (patch, gum etc.) or any form of vaping.

ADDITIONAL INDIVIDUALS TO BE COVERED

If applying for Couple, Single Parent Family 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 ☐ Nonsmoker	☐ Yes ☐ No
					☐ Smoker ☐ Nonsmoker	☐ Yes ☐ No
					☐ Smoker ☐ Nonsmoker	☐ Yes ☐ No
					☐ Smoker ☐ Nonsmoker	☐ 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 & attach proof of enrollment
	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 _____ (insert TPA name) 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 NOT smoked or vaped, or used any form of tobacco, nicotine or cannabis product, in the last 12 months. Including, but not limited to cigarettes, cigars, cigarillos, pipe, cannabis (including medical cannabis, recreational cannabis whether smoked, vaped or used in any digestible format), snuff, chewing tobacco or nicotine products (patch, gum etc.) or any form of vaping.

v) **Copies of both the Applicants drivers license and spouses (if applicable) are attached with this** application**. If no drivers license then copy of passport or SIN.**

vi) **For Dependent Children up to age 12 – Copy of their birth certificate and children over age 12 a copy of their SIN.**

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)

ACCEPTANCE AND SIGNATURE SUBMISSION

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.

Authorized Signature _____

Name: _____

Dated (DD/MM/YYYY) _____

Global Benefits Advisors