Health, Drug, Dental and Travel Insurance APPLICATION

TO APPLY FOR YOUR HEALTH PLUS™ INSURANCE, YOU CAN:
Complete an **ONLINE application.** You'll be able to keep a completed copy for your file.

OR

Complete and send this PDF application

by EMAIL: apply@healthplusinsurance.ca
by POST: Loran Insurance Limited
200 Consumers Road, Suite 205, Toronto, ON M2J 4R4

AFTER YOU APPLY: We'll review your application and be in touch by email within 3 business days to confirm your coverage.

If you need help or have questions about the application, please contact us:
CALL 1-877-218-0394 or 416-498-6944 EMAIL: apply@healthplusinsurance.ca

APPLICANT

Name _____ Date of Birth _____ (yyyy/mm/dd) ◯ Male ◯ Female

Address _____
Street No. Street Name | Unit / Apt. / Suite | City | Province | Postal Code

Phone Residence _____ Cell _____ Business _____

E-mail Address _____ Occupation _____

Employer _____ Address _____

Health Plus™ Plan Choice ◯ Optimum ◯ Priority **Requested Coverage** ◯ Single ◯ Dual ◯ Family

If you are applying for Dual or Family Coverage, please complete the Dependents information below.

DEPENDENTS

FIRST NAME	LAST NAME	GENDER	DATE OF BIRTH (yyyy / mm/ dd)	Children who are 21 or older must be registered as a full-time student or qualify as a disabled dependent.
Spouse		◯ Male ◯ Female		
Dependent (1)		◯ Male ◯ Female		Student ◯ Yes ◯ No Disabled ◯ Yes ◯ No
Dependent (2)		◯ Male ◯ Female		Student ◯ Yes ◯ No Disabled ◯ Yes ◯ No
Dependent (3)		◯ Male ◯ Female		Student ◯ Yes ◯ No Disabled ◯ Yes ◯ No
Dependent (4)		◯ Male ◯ Female		Student ◯ Yes ◯ No Disabled ◯ Yes ◯ No

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STATEMENT OF HEALTH

Please check YES or NO to all questions for yourself, spouse and eligible dependents and provide additional detail, where "Yes" is indicated. *If additional space is required, please attach a separate sheet.*

1. Personal Physician/s *(If you do not have a doctor, please indicate "none")*

Applicant: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

Spouse: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

Dependent 1: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

Dependent 2: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

Dependent 3: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

Dependent 4: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____

Reason, Diagnosis and Treatment

2. Do you or any of your dependents have any reason to believe you are not in good health, or have knowledge of any condition that might require entry into a hospital or any surgical, medical or psychiatric treatment?

Applicant		Spouse		Dependent	
Yes	No	Yes	No	Yes	No
○	○	○	○	○	○

DETAILS:

3. Do you, your spouse or any listed dependent children currently take or use any prescription drugs or have a prescription for which refills are currently authorized? Note: prescription drugs include oral medication, injectables, creams, drops and serum.

Applicant		Spouse		Dependent	
Yes	No	Yes	No	Yes	No
○	○	○	○	○	○

STATEMENT OF HEALTH CONT'D

DETAILS: Please complete or attach a copy of your detailed pharmacy receipt.

Name	Name of medication	DIN #	Frequency of Refills	Cost

4. Have you, your spouse or any listed dependent children EVER been treated for, consulted or received advice from a physician or specialist or had any indication of any of the following conditions?
Please check Yes or No to all questions and if yes, circle the specific medical condition.

		Applicant		Spouse		Dependent	
		Yes	No	Yes	No	Yes	No
4.1	High blood pressure, stroke, TIA (transient ischemic attack) or chest pain	○	○	○	○	○	○
4.2	High cholesterol or any other blood disorder, heart or circulatory disorder	○	○	○	○	○	○
4.3	Nervous, mental, emotional or neurological disorder (including depression, anxiety, chronic fatigue or fibromyalgia)	○	○	○	○	○	○
4.4	Liver disease or disorder including hepatitis	○	○	○	○	○	○
4.5	Stomach, intestinal, bladder, bowel or kidney disorder (including ulcers)	○	○	○	○	○	○
4.6	AIDS, ARC (AIDS Related Complex), HIV or other Immunological Disorders	○	○	○	○	○	○
4.7	Osteo or Rheumatoid Arthritis, Osteoporosis, Bone Density Loss, Back, Joint or Muscle Pain	○	○	○	○	○	○
4.8	Lung Condition, Respiratory Condition including COPD, Asthma or Allergies	○	○	○	○	○	○
4.9	Cancer, tumour or any growth	○	○	○	○	○	○
4.10	Skin disorder including Psoriasis and Eczema	○	○	○	○	○	○
4.11	Chronic headaches or migraines	○	○	○	○	○	○
4.12	Diabetes, except gestational	○	○	○	○	○	○
4.13	Any other condition, disease or disorder	○	○	○	○	○	○

DETAILS:

Question Number	Name	Conditions/symptoms, duration, tests, results and treatment	Date yyyy/mm/dd	Name and address of healthcare provider, clinic / hospital

STATEMENT OF HEALTH CONT'D

5. **Within the last 5 years, have you or any of your dependents consulted a doctor or any other health care practitioner, other than noted above, for ECGs, blood tests, X-rays, or any other tests, or had surgery or received any treatment in a hospital?**

Applicant		Spouse		Dependent	
Yes	No	Yes	No	Yes	No
○	○	○	○	○	○

DETAILS:

6. **Applicant:** **Height** _____ ○ Feet or ○ Centimeters Weight _____ ○ Pounds or ○ Kilograms

   Spouse: **Height** _____ ○ Feet or ○ Centimeters Weight _____ ○ Pounds or ○ Kilograms

7. **Have you or your spouse gained or lost 15 lbs (7 kgs) or more in the past year?**

Applicant		Spouse	
Yes	No	Yes	No
○	○	○	○

Amount gained: _____ Amount lost: _____
Reason:

8. **Within the past 12 months, have you used any tobacco/nicotine product?**

Applicant		Spouse	
Yes	No	Yes	No
○	○	○	○

9. **When were you last examined by a dentist?**

Applicant: Date _____ **Spouse: Date** _____

Child: Name _____ **Date** _____ **Child: Name** _____ **Date** _____

Child: Name _____ **Date** _____ **Child: Name** _____ **Date** _____

Are you, your spouse or any dependent child in need of, or do you expect to receive dental treatment of any kind, other than routine examinations, cleaning and scaling within the next 12 months? If Yes, please provide full details.

Applicant		Spouse		Dependent	
Yes	No	Yes	No	Yes	No
○	○	○	○	○	○

DETAILS

Name	Treatment

STATEMENT OF HEALTH CONT'D

DENTIST INFORMATION

	Dentist Name	Telephone
Applicant		
Spouse		
Child		
Child		
Child		
Child		

INSURANCE HISTORY

1. **Do you have in force or pending Life Insurance, Critical Illness Insurance, Disability Insurance or Long Term Care Insurance?**

Applicant		Spouse	
Yes	No	Yes	No
○	○	○	○

DETAILS:

Name	Insurance Company	Amount	Type of Plan	Year of Issue

2. **Have you or your spouse ever made an application for insurance that was declined, modified or offered on special terms?**

Applicant		Spouse	
Yes	No	Yes	No
○	○	○	○

DETAILS:

Please continue to Page 6 to COMPLETE AND SIGN the Personal Declaration and Pre-authorized Payment sections.

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PERSONAL DECLARATION

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits on my dependents, **I CONFIRM THAT I AM AUTHORIZED** to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to Loran Insurance Limited, Beneplan Inc. and Green Shield Canada for the purpose of underwriting, administration, claims processing and the enrollment of myself and my dependents in this insurance plan. **Failure to disclose or falsifying information regarding my health and/or that of spouse / partner and / or dependent children could result in denial of a claim and the cancellation or modification of this coverage.**

I DECLARE that I, my spouse / partner and all listed dependents are covered by our Provincial Government Health Plan.

I ACCEPT that the coverage applied for under this plan is subject to the approval of the plan underwriters and may be declined based on their medical insurability guidelines. Coverage shall not become effective until the first of the month following approval.

I CONSENT TO AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medically related facility or pharmacy, insurance company, or the Medical Information Bureau to provide and exchange information with the plan underwriters for the purpose of this Application for insurance and any subsequent claim.

Applicant Signature: _____

Spouse Signature: _____

Signed at: _____ (City / Town), _____ (Province) this _____ (Date) day of _____ (Month), _____ (Year)

PRE-AUTHORIZED PAYMENT

I/We hereby authorize Beneplan Inc. **to withdraw premium payments from my/our account**. Should there be any change in either the amount or premium due date, Beneplan Inc. will give the applicant written notice. Beneplan Inc. 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 Beneplan Inc. thirty (30) days prior to the next premium due date** requesting cancellation by either the applicant or account holder(s).

ACCOUNT HOLDER/PAYOR SIGNATURE _____

ACCOUNT HOLDER/PAYOR SIGNATURE _____

BANK INFORMATION: Please complete OR include a cheque marked VOID with your Application.

BANK NAME _____

BRANCH/ ADDRESS _____

BRANCH TRANSIT NUMBER_____**ACCOUNT NUMBER**_____

SEND SIGNED APPLICATION
TO: LORAN Insurance Limited

200 Consumers Road, Suite 205, Toronto, Ontario M2J 4R4
Phone: 416-498-6944 or 1-877-218-0394 • Fax: 416-498-4766
Email: apply@healthplusinsurance.ca

Insurance Management Services: Beneplan Inc.

150 Ferrand Drive, Suite 500, Toronto, Ontario M3C 3E5
Phone: 416-863-6718 or 1-800-387-1670
Fax: 416-863-5157

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