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: Health Plus Insurance
390 Wellesley Street East, Suite 20, Toronto ON M4X 1H6

AFTER YOU APPLY: We'll review your application and be in touch promptly 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 ◯ Couple ◯ Single Parent ◯ Family

Are you a member of an Association offering Health Plus as a membership benefit?

No ◯ Yes ◯ Name of Association _____

If you are applying for Couple, Single Parent or Family Coverage, please complete the Dependents information following.

DEPENDENTS

FIRST NAME	LAST NAME	SEX	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

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 _____ YYYY-MM-DD

Reason, Diagnosis and Treatment

Spouse: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____ YYYY-MM-DD

Reason, Diagnosis and Treatment

Dependent 1: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____ YYYY-MM-DD

Reason, Diagnosis and Treatment

Dependent 2: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____ YYYY-MM-DD

Reason, Diagnosis and Treatment

Dependent 3: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____ YYYY-MM-DD

Reason, Diagnosis and Treatment

Dependent 4: Physician Name _____ Phone _____

Address _____ Date Last Consulted _____ YYYY-MM-DD

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
○	○	○	○	○	○

3. In the past 12 months have you or any of your dependents received treatment from any paramedical practitioner? Example: massage therapist, chiropractor, psychologist, speech therapist, physiotherapist, osteopath, podiatrist or acupuncturist.

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

DETAILS (If "Yes" to question 2 or 3):

4. 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

5. 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
5.1	High blood pressure, stroke, TIA (transient ischemic attack) or chest pain	○	○	○	○	○	○
5.2	High cholesterol or any other blood disorder, heart or circulatory disorder	○	○	○	○	○	○
5.3	Nervous, mental, emotional or neurological disorder (including depression, anxiety, chronic fatigue or fibromyalgia)	○	○	○	○	○	○
5.4	Liver disease or disorder including hepatitis	○	○	○	○	○	○
5.5	Stomach, intestinal, bladder, bowel or kidney disorder (including ulcers)	○	○	○	○	○	○
5.6	AIDS, ARC (AIDS Related Complex), HIV or other Immunological Disorders	○	○	○	○	○	○
5.7	Osteo or Rheumatoid Arthritis, Osteoporosis, Bone Density Loss, Back, Joint or Muscle Pain	○	○	○	○	○	○
5.8	Lung/Respiratory Conditions including COPD/Asthma/Allergies/Apnea	○	○	○	○	○	○
5.9	Cancer, tumour or any growth	○	○	○	○	○	○
5.10	Skin disorder including Psoriasis and Eczema	○	○	○	○	○	○
5.11	Chronic headaches or Migraines	○	○	○	○	○	○
5.12	Diabetes including gestational, Prediabetes (impaired glucose tolerance or impaired fasting glucose) or fasting blood glucose of 5.6 mmol/L or higher	○	○	○	○	○	○
5.13	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

6. 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:

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

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

8. 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:

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

Applicant		Spouse	
Yes	No	Yes	No
○	○	○	○

10. When were you last examined by a dentist?

Applicant: Date _____ (YYYY-MM-DD) **Spouse: Date** _____ (YYYY-MM-DD)

Child: Name _____ **Date** _____ (YYYY-MM-DD) **Child: Name** _____ **Date** _____ (YYYY-MM-DD)

Child: Name _____ **Date** _____ (YYYY-MM-DD) **Child: Name** _____ **Date** _____ (YYYY-MM-DD)

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
○	○	○	○	○	○

Do you go to the dentist more than once every 9 months for cleaning or has your dentist advised that you have a gum condition requiring treatment?

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		

OTHER INSURANCE

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:

COORDINATION OF BENEFITS (COB):

Are you or your dependents currently covered under another group medical insurance policy that will not be replaced by your Health Plus coverage?* Yes ○ No ○

Are you or your dependents currently covered under another group dental insurance policy that will not be replaced by your Health Plus coverage?* Yes ○ No ○

*** If the policyholder is someone other than you or a dependent listed on this application, please provide:**

Last Name_____ **First Name**_____ **Date of Birth** _____
YYYY-MM-DD

PERSONAL DECLARATION

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge. Any copy of this authorization shall be as valid as the original.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE AND EXCHANGE** of information contained in this form and subsequent claims payment, between Health Plus Insurance, MDM Insurance Services Inc. (MDM) and The Cooperators Group Limited for the purposes 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 my 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 _____ **PLEASE PRINT NAME** _____

SPOUSE SIGNATURE _____ **PLEASE PRINT NAME** _____

SIGNED AT: _____, _____ **on** _____
City / Town Province YYYY-MM-DD

IF YOUR HEALTH PLUS PLAN MONTHLY FEE IS BEING PAID BY YOUR EMPLOYER DIRECTLY TO US, PLEASE CHECK HERE ☐

If your Employer will be paying for your Health Plus insurance, leave the next sections *Pre-Authorized Payment* and *Authorization to Deposit Claims Payment* blank, and submit your application.

Health Plus™ MDM Insurance Services Inc. the co-operators beneplan

PRE-AUTHORIZED PAYMENT

I/We hereby authorize MDM Insurance Services Inc. (MDM) to withdraw premium payments from my/our account. I agree to waive my right to receive pre-notification of the amount of any pre-authorized payment before the debit is processed. Should there be any change in either the amount of premium or due date, MDM will provide written notice. MDM may terminate coverage should a withdrawal be refused for any reason and the financial institution shall in no way be liable should such an event occur. **This authorization shall remain valid unless written notice is received by MDM thirty (30) days prior to the next premium due date requesting cancellation by either the applicant or account holder(s).**

ACCOUNT HOLDER/PAYOR SIGNATURE _____ **PLEASE PRINT NAME** _____

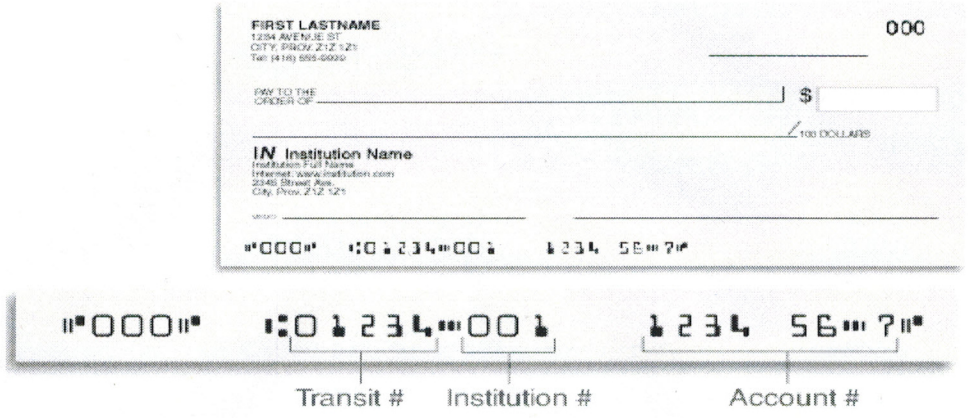
ACCOUNT HOLDER/PAYOR SIGNATURE _____ **PLEASE PRINT NAME** _____

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

NAME OF FINANCIAL INSTITUTION _____

BRANCH/ ADDRESS _____

BRANCH TRANSIT # (5 digits) _____ **INSTITUTION #** (3 digits) _____ **ACCOUNT #** _____



AUTHORIZATION TO DEPOSIT CLAIMS PAYMENTS

I authorize MDM to deposit claims payments directly to the bank account provided above for Pre-Authorized Payment.

Yes ◯ No ◯

If no, you will have the opportunity to provide an alternate account through the online member portal after you are enrolled in the Plan.

SIGNATURE _____ **PLEASE PRINT NAME** _____

SEND SIGNED APPLICATION TO:
Health Plus Insurance

Email: apply@healthplusinsurance.ca
390 Wellesley Street East, Suite 20, Toronto ON M4X 1H6
Phone: 416-498-6944 or 1-877-218-0394 • Fax: 437-266-8854

Administration is provided by:

MDM Insurance Services Inc.
834 Gordon Street, Guelph ON N1G 1Y7
Email: inquiry@mdm-insurance.com • Phone: 1-800-838-1531

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