

All applicants must complete **SECTIONS A, B, C** and **SECTIONS E and F**. If you are applying for **ZONE plans 4, 5 or 6**, please also complete **SECTION D**.

SECTION A — Contact Information

Last Name:	First Name:	Initial:
Street Address:	Apt. No:	
City/Town:	Province:	Postal Code:
Home Tel: ()	Business Tel: ()	Cell: ()

***Email Address** (so GSC can process your application and communicate approval more quickly):

SECTION B — Coverage Information

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

- Single coverage** *Applies to applicant only*
- Couple coverage** *Applies to applicant and spouse/partner OR applicant and one dependent child under age 21*
- Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

Select one plan option:

- ZONE 1** **ZONE 4**
- ZONE 2** **ZONE 5**
- ZONE 3** **ZONE 6**
- ZONE Fundamental Plan**

A: Are you covered, or were you covered under any other health plan? Yes No

B: If yes, please indicate if coverage was: Group Individual

C: When does or did your coverage end? (YYYY/MM/DD):

Add optional Hospital Accommodation
 Yes No

D: Name of insurance carrier:

Total Monthly Rate: \$

SECTION C — Individuals to be Covered — please complete in full for EACH person

Last Name	First Name	Initial	Gender	Date of Birth (YYYY/MM/DD)	Age
Applicant:			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Spouse/Partner:			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child: <i>(must be under age 21)</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child: <i>(must be under age 21)</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child: <i>(must be under age 21)</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child: <i>(must be under age 21)</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female		

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

If you are applying for **ZONE plans 1, 2, 3** or the **ZONE Fundamental plan**, please proceed to complete **SECTIONS E and F**.

If you are applying for **ZONE plans 4, 5 or 6** and/or the optional **Hospital Accommodation benefit**, please complete **SECTIONS D, E and F**.

FOR ADVISOR USE ONLY		
Advisor Code:	Advisor Name (first and last):	Advisor Email Address:
Office Code: GPB01	Office Name: Associated Group Marketing Services	Advisor Telephone Number:
MGA Code: MG358	MGA Name: Prosum Health Benefits Inc.	

Please complete **SECTION D** if you are applying for ZONE plans 4, 5 or 6 **OR** if you have selected the optional Hospital Accommodation benefit. Otherwise, proceed to **SECTION E**.

SECTION D — Statement of Health and Prescription Drug Information

1 Have you, your spouse/partner and/or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of the following conditions? (Check , "Yes" or "No" for all questions **AND** circle the specific medical condition if applicable.)

	Applicant	Spouse / Partner	Dependent(s)
A: Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures or paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B: ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C: Stomach, intestinal, kidney, bladder or liver disorder including hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D: Infertility, reproductive disorder or menopause	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E: Colitis, Crohn's, irritable bowel syndrome, ulcers, hernia, reflux or persistent heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F: Circulatory, heart or vascular disease, high blood pressure, angina, stroke or TIA (mini-stroke)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
G: Elevated cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
H: Alcoholism or drug dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
I: Skin disorders including acne, rosacea, psoriasis or eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
J: AIDS, ARC (AIDS related complex), HIV or other immunological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
K: Arthritis/rheumatism, osteoporosis, bone density loss, back, joint or muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
L: Lung condition, respiratory conditions including COPD, asthma or allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
M: Headaches or migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
N: Cancer, tumor or leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
O: Sexually transmitted diseases or infections (STDs or STIs) or recurring infections including cold sores or herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
P: Diabetes, endocrine, hormonal or thyroid disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Q: Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
R: Other condition, disease, disorder or injury not listed above – please check (<input type="checkbox"/>) Applicant, Spouse/Partner or Dependent(s) and specify below:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any condition(s) in SECTION D-1 above, please identify which question [letter(s) A–R] and provide details below:

Question Letter	First Name of Person	Date(s) Diagnosed (YYYY/MM)	Drugs / Treatment	Nature of Illness, Injury or Condition and Results of Treatment

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

2 Do you, your spouse/partner and/or any listed dependent children currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? Yes No
 Prescription drugs include oral medications, injectables, creams, drops or serum.

If you answered "Yes" to this question, please provide details below:

Prescription Drug Information

First Name of Person	Name of Drug	Drug Identification Number (DIN)	Strength	Daily Dosage	Length of Time Using This Drug	Number of Refills Per Year	Date of Last Refill (YYYY/MM/DD)

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

	Applicant	Spouse / Partner	Dependent(s)
3 Have you, your spouse/partner and/or any listed dependent children been hospitalized in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Do you, your spouse/partner and/or any listed dependent children expect to be hospitalized in the next six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to question 3 or 4, please provide details below:

First Name of Person	Illness/Injury Treated	Date of Illness, Injury or Confinement (YYYY/MM)	Actual or Anticipated Number of Days in Hospital	Details/Outcome of Illness or Injury

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

	Applicant	Spouse / Partner	Dependent(s)
5 Have you, your spouse/partner and/or any listed dependent children consulted a physician annually over the last two (2) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Number: ()

Reminder: BOTH Payment Authorization AND Declaration sections must be signed.

SECTION E — Payment Information

Payment for the first two months of coverage is due on your coverage effective date. Subsequent payments will be made 30 days in advance of the month for which coverage is to be provided. For example, if your coverage is effective on March 1, you would pay for March and April on or about March 1. Depending on how you choose to pay, we will withdraw payment from your bank account or charge your credit card for your May coverage on or about April 1. Questions about payments? Call 1.844.554.2522.

Method of Payment

Pre-authorized Credit Card Mastercard Visa American Express

Name (as it appears on card): _____ Credit Card Number: _____ Expiry: _____
Address: _____ City/Town: _____ Province: _____ Postal Code: _____

Pre-authorized Debit PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID" – Applications received without a "VOID" cheque cannot be processed.

Is this account Personal or Business? Personal Business
Is this a joint account? Yes No If "Yes", does this joint account require more than one signature? Yes No
If two signatures are required, information for both Account Holders must be provided:
1st Account Holder 2nd Account Holder
Name: _____ Name: _____
Address: _____ Address (if different from 1st payor): _____
City/Town: _____ Province: _____ Postal Code: _____ City/Town: _____ Province: _____ Postal Code: _____
Telephone Number: () Telephone Number: ()

Payment Authorization

I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.cdnpay.ca. I/We hereby authorize GSC to withdraw payments from the account specified above on or about the first business day of the month as outlined above. Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change. GSC may terminate coverage in the event that a withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur. I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.cdnpay.ca. I/We represent and warrant that the payment information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

X Signature(s) Required:
Signature of Account Holder: _____ Date (YYYY/MM/DD): _____
2nd Signature (if joint account): _____ Date (YYYY/MM/DD): _____

SECTION F — Declarations and Authorizations — ALL APPLICANTS MUST SIGN

NOTE: This authorization must be signed by the applicant and spouse/partner (if applicable). The information provided on this form is confidential.

By signing this application form, I/we agree that the statements contained herein are true and complete, to the best of my/our knowledge and form the basis for any coverage approved. I am authorized to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits. I/We understand that 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/We understand that it is my/our obligation to notify GSC 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. 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 dependent children, to exchange such information as is needed for the purpose of this application, to administer benefit claims, to provide access to other GSC services, and/or to confirm the accuracy of the information with GSC. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and understand that information may be shared with my Advisor of record for the purposes previously identified. A reproduction of this consent and authorization shall be as valid as the original.

X Signature(s) Required:
Signature of Applicant: _____ Date (YYYY/MM/DD): _____
Signature of Spouse/Partner: _____ Date (YYYY/MM/DD): _____

ADVISOR'S REPORT – For Advisor/Agent Use Only

I confirm that I have disclosed the following information to the applicant: the name of the company or companies I represent; that I receive commissions for the sale of health and dental products and may receive bonuses or other incentives; and any conflicts of interest I may have with respect to this transaction.

Advisor Name (first and last): _____ Advisor Code: _____ Advisor Signature: _____

Please send applications to GSC, Individual Products Team, 5140 Yonge St., Suite 2100, Toronto, ON M2N 6L7