



Application for Health Insurance - Good, Better or Best Programs

All provinces except Quebec & Territories

Section 1: General Information

YOUR NAME LAST NAME		FIRST NAME		INITIAL		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON LAW <input type="checkbox"/> OTHER	
DATE OF BIRTH (DD/MM/YYYY)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		OCCUPATION		HEIGHT	
HOME ADDRESS		CITY		PROVINCE		POSTAL CODE	
HOME TELEPHONE		WORKPLACE TELEPHONE		FAX			
EMAIL ADDRESS		LAST DATE OF EMPLOYMENT					
ANNUAL EARNINGS		MINIMUM NUMBER OF HOURS WORKED		YOUR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> INCORPORATED <input type="checkbox"/> OTHER			
NAME OF APPLICANTS EMPLOYER							

Section 2: Coverage Selection & Plan Choice

1. Please indicate your level of coverage: Single Family Couple
* The oldest person on the application determines the age band and rate (**Applicant must be under age 65**)

2. Please choose your Benefits Program: Good* Better Best Include Optional Catastrophic Drugs
* Applies to existing clients of GroupHEALTH Global only.

3. Please choose Extended Health Care ONLY or Extended Health Care + Dental: EHC Only EHC + Dental
* Dental is mandatory under the "Good" plan

Section 3: Dependent Information

Last Name	First Name	Gender	Birth date (DD/MM/YYYY)	Height	Weight
Spouse:					
Child:					
Child:					
Child:					
Child:					

If your Spouse is currently under another Health Care benefits plan, please provide the following information:

SPOUSES EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
--	--------------------------------------	------------------------

Section 4: Privacy & Confidentiality

We strictly protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of details shared about any plan member and his or her dependent's benefits. In terms of telephone inquiries to GroupHEALTH Global Customer Service, the information provided varies based on the relationship of the person making the inquiry to the insured (e.g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Personal Health Declaration

Please complete this Personal Health Declaration in full. In particular, if you answer "YES" to any of the medical questions below, please provide details in Section 2. Questions or need further assistance? Please call us toll-free at **1-888-719-3077** and ask for the SoloPLUS Department.

Section 1: Health Declaration

This application is not valid unless the medical information requested is accurately completed and application is signed by all applicants (18 years & older)

Have you or any of your dependents ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, medication/dosage, and frequency of episodes, (if applicable) in Section 2.

1. Have you ever been treated, counselled, received advice for or ever had any known indication of: (please circle the condition(s) that apply to you or your dependents)	APPLICANT	SPOUSE	DEPENDENTS
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood 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
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<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) Diabetes, Colitis or Crohn's?	<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) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<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) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<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) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<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) Infertility / Reproductive Disorder, Menopause, Prostate 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
h) Chronic Headaches, Migraines or recurrent infections?	<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) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory 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
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney 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) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<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) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	<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) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure 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
n) Skin Disorder (including Acne)?	<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) Alcoholism or Drug Abuse/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
p) Other Condition/Disease/Disorder/Injury - Please Specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, X-rays or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you or are you currently waiting on results from any recent testing?	<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. Are you currently taking or have you been prescribed any prescription medications or discontinued a prescription in the last 3 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
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 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
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing, piloting aircraft, or bungee jumping?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 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

Section 4: Privacy & Confidentiality

I understand that to be eligible for the insurance for which I am applying, I must at all times be covered under my provincial government health plan and be a Canadian resident.

I agree that the statements and answers in the Declaration, on any medical examination and in any written statements or answers furnished as evidence of my insurability shall form the basis of any insurance granted under the terms of the policy issued to me. I understand that Echelon General Insurance Company, or their service providers reserve the right to verify the answers provided to the questions contained in this Personal Health Declaration at the time of any claim for benefits under the policy issued to me. I declare that all statements and answers recorded in this Declaration are as given by me and are true and complete.

I hereby authorize the Insurer of its service providers, for underwriting and administration of insurance and claims paying purposes only:

- (a) To gather only that information necessary for the objective of the Health & Dental Benefits or Disability Benefits file from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the objective of this file;
- (b) To disclose only the necessary personal information it has relating to me to these same persons and organizations, or as required by law;
- (c) To request a personal investigation report relating to me.

A photocopy of this Authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ 20_____

Applicant's Signature _____

Signature of Spouse (if dependent coverage applied for) _____

Signature of Dependent(s) - (if above age of majority) _____

This authorization is valid for the period required to achieve the ends for which it was requested.

Section 5: Broker Information (if applicable)

Arranged by:



Phone: 250-475-0557

Fax: 250-475-0557

Toll Free: 1-866-475-0552



SoloPLUS

www.soloplus.com

GroupHEALTH Global
P.O. Box 31015
Barrie, Ontario L4N 0B3

Phone: (705) 719-3077
Toll - free: 1-888-719-3077
Fax: (705) 719-3078