SoloPLUS™

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

Application for Health Insurance - Better or Best Programs

All provinces except Quebec & Territories

Section 1: General Information

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ COMMON LAW ☐ OTHER_____		
DATE OF BIRTH (DD/MM/YYYY)	GENDER ☐ MALE ☐ FEMALE	OCCUPATION	HEIGHT	WEIGHT	
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 ☐ EMPLOYEE ☐ SOLE PROPRIETOR ☐ CONTRACTOR ☐ INCORPORATED ☐ 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 75)**

2. Please choose your Benefits Program: ☐ Better ☐ Best ☐ Include Optional Catastrophic Drugs

3. Please choose Extended Health Care ONLY or Extended Health Care + Dental: ☐ EHC Only ☐ EHC + Dental

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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
c) Diabetes, Colitis or Crohn's?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fybromyalgia?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
h) Chronic Headaches, Migraines or recurrent infections?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney Disorder?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
n) Skin Disorder (including Acne)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
o) Alcoholism or Drug Abuse/Dependency?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
p) Other Condition/Disease/Disorder/Injury - Please Specify:_____	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
q) Are you currently receiving treatments or have you consulted a Dental professional in the last 9 months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
r) Have you had any major Dental treatment within the last 5 years?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
4. Are you currently taking or have you been prescribed any prescription medications or discontinued a perscription in the last 3 months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Section 2: Details for questions answered "YES" on Personal Health Declaration Section 1

Please provide details for any question answered "YES" in Section 1. If additional space is required, please attach a separate sheet.

Question #	Name of Applicant, Spouse or Dependent	Nature of Disorder	Duration	Frequency of Episodes	Date of Recovery	Medication / Treatment	Daily Dosage	Approximate Monthly Cost ($)

If additional space is required, please attach a separate sheet.

Full name and address of your regular attending physician:		If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. If the answer is "none"; state "none".
NAME OF APPLICANT'S PHYSICIAN		ADDRESS
LAST VISIT (MONTH/YEAR)	REASON	RESULT
NAME OF SPOUSE'S PHYSICIAN		ADDRESS
LAST VISIT (MONTH/YEAR)	REASON	RESULT
NAME OF DEPENDENT'S PHYSICIAN		ADDRESS
LAST VISIT (MONTH/YEAR)	REASON	RESULT

Section 3: Optional Benefits

Please indicate here which Optional Benefits you will be applying for and a representative will forward the appropriate forms.
Optional Benefits can be selected to enhance your overall protection or address specific personal needs. A separate application form is required.

- ☐ **Disability Benefits:** Requires separate Application Form.
- ☐ **Critical Illness Benefit:** Requires separate Application Form.
- ☐ **Accidental Death & Dismemberment:** Requires separate Application Form.

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 SSQ Financial Group, 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 of 60 days from the above date.

Section 5: Partner Information (if applicable)

Broker Name: _____

Company Name: _____

Email Address: _____

SoloPLUS™

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