Application for Soloplus – Better or Best Programs

Available in all provinces except Quebec & Territories

APPLICANT INFORMATION

Applicant First Name	Applicant Last Name	Sex	Height	Weight
		☐ Male ☐ Female		

Date of Birth (DD/MM/YYYY)	Marital Status
	☐ Married ☐ Single ☐ Common Law ☐ Other: _____

Principal Street Address		
City	**Province**	**Postal Code**
Home Telephone	**Workplace Telephone**	**Provincial Health Care No.**

Email Address	Last Date of Employment

COVERAGE SELECTION & PLAN CHOICE

Please indicate your level of coverage:
The oldest person on the application determines the age band and rate
Applicant must be under age 75

☐ Single ☐ Couple ☐ Family

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

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

DEPENDENT INFORMATION

LAST NAME	FIRST NAME	GENDER	BIRTH DATE (DD/MM/YYYY)	HEIGHT	WEIGHT
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

Spouse's Employer (or Name of the Other Plan)	Other Health Care Plan Policy Number	Insurance Company Name

PRIVACY STATEMENT

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 Benefit Solutions, the information provided varies based on the relationship of the person making the inquiry to the insured (plan member or dependent). After the caller has been authenticated, only information pertaining to the specific claim or treatment in question is shared.

PERSONAL HEALTH DECLARATION **Please complete this Personal Health Declaration in full.**

This application is not valid unless the medical information requested is accurately completed and the application is signed by all applicants (18 year & 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 the following section.

		Applicant		Spouse		Dependents	
1.	**Have you ever been treated, counselled, received advice for or ever had any known indication of:**						
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 Fibromyalgia?	☐ 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 healthcare practitioner for ECG's, 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 prescription 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	
9.	**Are you currently pregnant?** If Yes, what is your expected due date? _____	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	

DETAILS FOR QUESTIONS ANSWERED "YES" ON THE PERSONAL HEALTH DECLARATION

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

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

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**

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.

☐ **Disability Benefits** ☐ **Accidental Death & Dismemberment** ☐ **Critical Illness**

COVERAGE SELECTION

☐ **Temporary Total Disability**

☐ **Permanent Total Disability** – Provides a benefit of up to 5x annual earnings after 25 months to a maximum of $500,000 ☐ **1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x**

☐ **Accidental Death and Dismemberment** –
Pick a lump sum in increments of $50,000. Minimum benefit is $50,000, Maximum benefit is $500,000. **$** _____

☐ **Critical Illness**
Pick a lump sum in increments of $5,000. Minimum benefit is $10,000, Maximum benefit is $50,000. **$** _____

OPTIONAL DISABILITY BENEFITS *The below information is only required if you are applying for optional disability benefits

Job Title	Industry	Primary Duties

Annual Earnings	Minimum Number of Hours Worked	Your Employment Status
		☐ Employee ☐ Contractor ☐ Sole Proprietor ☐ Self Employed ☐ Incorporated ☐ Other

Name of Employer

PRIVACY ACKNOWLEDGMENT

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 GroupHEALTH, 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.

For additional information on privacy please visit: https://www.grouphealth.ca/privacy-and-legal/

I hereby authorize the Insurer or 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, investigations, 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.

An electronic version of this authorization shall be as valid as the original.

Please send the completed document:
Email soloplus.specialist@grouphealth.ca | **Fax** 1.877.542.4112 | **Mail** GroupHEALTH Benefit Solutions 15315 31st Avenue, Surrey, BC, V3Z 6X2

Applicant's Signature	Date

Signature of Spouse (if dependent coverage applied for)	Date

Signature of Dependent(s) – (if above age of majority)	Date

PARTNER INFORMATION (if applicable)

Broker Name:

Company Name:

Email Address: