



HEALTHSURE™ INDIVIDUAL ENROLLMENT FORM

At United Benefits Group we are here to help. If you have any questions or require and assistance in completing the HealthSure™ insurance plan enrollment form just call our office toll free at 1-888-264-8020 or (403) 264-8020 in Calgary and one of the individuals on our exceptional client services support team would be happy to assist you.

United Benefits Group utilizes certified SSL encryption from Entrust to protect the security of the information you provide in your enrollment form (Entrust is recognized amongst the top SSL encryption security systems in the world).



Name First Name Last Name Middle Initial(s)

Mailing Address

City Province Postal Code

Phone Cell Alternate Email

Date of Birth (MM/DD/YY) Gender Male Female

Smoking Status Non-smoker Smoker If you are not applying for MAI Premium which contains Critical Illness Insurance, you do not have to answer Smoking Status. Non-Smoker rates apply to MAI Premium applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the last 12 months.

Are you a Canadian Resident? Yes No Provincial Health Plan Coverage? Yes No

You must be a Canadian resident residing in Canada in order to obtain the prompt access to health care that HealthSure™ provides.

You must be covered under a Provincial Health Care Plan in Canada in order to obtain the prompt access to health care that HealthSure™ provides.

Identity verification

Under Canadian Anti-money Laundering and Anti-Terrorism Legislation you must provide both your driver's license number and social insurance number in order to obtain insurance coverage in Canada.

Your Driver's License number Your Social Insurance Number

Would you like online access to view claims, address information, etc.? Yes No

PLAN INFORMATION

HealthSure™ Coverage Type: Single Couple Single with Children Family

SPOUSE INFORMATION (Complete if applicable)

Please complete this section if you are applying for Couple or Family coverage. CI Amount is optional for Spouse Coverage.

Table with 7 columns: First Name, Last Name, Date of Birth (MM/DD/YY), Gender (M/F), Smoking Status (Non-smoker, Smoker), OPTIONAL: CI Amount (Benefit Amount of \$25,000), Provincial Health Plan Coverage? (Yes, No)

ADDITIONAL INDIVIDUALS TO BE COVERED (Complete if applicable)

Please complete this section if you are applying for Family coverage. If you require more space, please attach a separate sheet.

Table with 7 columns: First Name, Last Name, Date of Birth (MM/DD/YY), Gender (M/F), Relationship to Applicant, Smoking Status (Non-smoker, Smoker), Provincial Health Plan Coverage? (Yes, No)

If your Dependent Child is age 19 or over, please complete the following information to confirm their eligibility:

MSH International (Canada) Ltd. requires annual confirmation of eligibility for all over-age dependents insured. To ensure accurate claims payments, a Request for Overage Dependent Coverage Form must be completed upon enrolment or as deemed necessary. If applicable, contact Administrative Services at 1-866-416-2259.

Table with 3 columns: First Name as Recorded Above, Full-time Student? (Yes, No), Name & Address of Accredited School, College or University (ATTACH PROOF OF ENROLMENT TO THIS FORM)

PLEASE SELECT THE PRIMARY INSURED PERSON APPLYING FOR COVERAGE

<30 30-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74

Monthly Premium Rates

<u>Age at Effective date of contract</u>	<u>Single</u>	<u>Couple</u>	<u>Single with Children**</u>	<u>Family</u>
Under 30	\$44.69	\$71.19	\$75.60	\$102.10
30 - 39	\$51.51	\$84.82	\$79.01	\$112.35
40 - 44	\$61.34	\$104.47	\$90.40	\$133.53
45 - 49	\$75.49	\$132.80	\$102.10	\$159.40
50 - 54	\$85.59	\$152.98	\$111.33	\$178.73
55 - 59	\$94.77	\$171.36	\$120.84	\$197.41
60 - 64	\$104.42	\$190.63	\$126.85	\$213.08
65 - 69	\$118.74	\$218.68	\$140.81	\$241.36

Based on the chosen age selection above, your HealthSure™ Insurance plan rate is shown in the table above.

OPTIONAL (HealthSure™ Premium) Critical Illness Insurance: Amount of Coverage \$25,000

- a. If you choose to you can add a Critical Illness benefit to your HealthSure™ Insurance Plan. This benefit will provide yourself, family member or key employee with a lump sum benefit of \$25,000 in the event of a covered condition such as Cancer, Heart Attack or Stroke or numerous other serious health conditions.
- b. There is no medical exam required to add Critical Illness benefit to your HealthSure™ Insurance Plan. Any pre-existing conditions such as Cancer would be excluded during the first 2 policy years but would then be covered after 2 years.
- c. Non-smoker rates apply to applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc) within the last 12 months.
- d. Renewal rates only, last age to apply for the Optional Critical Illness benefit is age 64.

CRITICAL ILLNESS INSURANCE - BENEFIT AMOUNT IS \$25,000

Monthly Premium Rates

NON-SMOKER RATES

<u>Age at Effective date of contract</u>	<u>Rate</u>
Under 25	\$6.61
25-29	\$8.92
30-34	\$11.23
35-39	\$13.65
40-44	\$18.69
45-49	\$28.55
50-54	\$40.41
55-59	\$53.74
60-64	\$90.36
65-69	\$132.75

SMOKER RATES

<u>Age at Effective date of contract</u>	<u>Rate</u>
Under 25	\$9.65
25-29	\$17.63
30-34	\$23.83
35-39	\$29.49
40-44	\$43.25
45-49	\$73.56
50-54	\$111.56
55-59	\$153.63
60-64	\$257.43
65-69	\$381.58

Based on the chosen age selection and smoking status above your Optional Critical Illness Insurance coverage rate is shown in one of the tables above. Note: this is an additional rate for each individual covered. Please add the rate(s) to your HealthSure™ Insurance plan rate for a total monthly premium (above).

PREMIUM PAYMENT OPTIONS Note: All premiums are subject to Provincial Sales Tax, where applicable.

MONTHLY payment options:

Credit Card **PAD** (Pre-Authorized Debit, complete section below).

ANNUAL payment options:

Credit Card **Cheque**

AUTHORIZATION: I authorize MSH International (Canada) Ltd. ("MSH") to debit my account as per the Method of Payment chosen above. Payments will be withdrawn on or around the 1st day of each month for monthly insurance premiums due. I understand this amount may change at a future date as specified in the Policy. MSH will, to the best of its ability, advise me in writing of the revised amount in advance of its effective date. The pre-authorized payment plan may be discontinued by me or MSH upon 30 days written notice. **DISHONoured TRANSACTIONS:** MSH will charge a \$35.00 fee for each dishonoured transaction (and charge this amount using the Method of Payment above). Privileges will be canceled if there are 2 dishonoured payments in the same policy year and full premium payment of balance of policy year will be required within 30 days.

CREDIT CARD: Complete the following



Card Number Expiry Date (MM/YY)

Cardholder Name: Signature: Date (MM/DD/YY)

CHEQUE: Make cheque payable to **MSH INTERNATIONAL (CANADA) TRUST**. Attach a cheque for the first month's premium. You will be billed for the balance once approved.

PAD (Pre-Authorized Debit) Agreement: Complete only if premium payment is made by Pre-Authorized Debit

Attach your VOID cheque **OR** complete the following section:

Account Holder Name(s)			
Address	City	Province	Postal Code
Financial Institution Name		Withdrawal Arrangement: <input type="checkbox"/> Fixed <input checked="" type="checkbox"/> Variable	
Address	City	Province	Postal Code
Financial Institution Number	Transit Number	Account Number	

RECOURSE: You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your Financial Institution or visit www.cdnpay.ca.

PAD AUTHORIZATION: I/We, as the Account Holder(s), authorize MSH International (Canada) Ltd. ("MSH") and the Financial Institution named above or as indicated on the attached VOID cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax and service charges for insurance under this Policy. The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/We agree to notify MSH in writing if there is any change to the banking information set out above. I/We waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/We agree that MSH will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales tax, service charges, or the increase to the PAD amount is a result of my/our request. I/We may cancel this PAD agreement at any time, subject to providing 30 days notice to MSH at the address on the bottom of this form. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD agreement at my/our Financial Institution or by visiting www.cdnpay.ca. I/We understand that cancellation of this PAD agreement will not have any effect on the insurance provided on this Policy provided that payment is received when due and is made in accordance with the terms of this Policy. This PAD agreement only applies to the method of payment.

Signature of Account Holder(s) **Date Signed** (MM/DD/YY)

PRE-EXISTING CONDITION LIMITATIONS

HEALTHSURE™ INSURANCE: Pre-existing Condition means: 1) A condition for which an Insured Person is given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation prior to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage; or 2) A condition which produced symptoms prior to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage. These symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests: a) The symptoms would allow one learned in medicine to make a diagnosis of the disorder; or b) The symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment. This includes, but is not limited to any condition for which the Insured Person is already on a Surgical/Procedural Waiting List in Canada. **Pre-existing Condition Limitation:** Benefits for HealthSure™ are limited for any Pre-Existing Condition that existed during the 24 months prior to the Insured Person's effective date of coverage. HealthSure™ coverage is not provided for any Pre-Existing Condition until after the Insured Person has been continuously insured for 24 months under this policy. This limitation does not apply to a newborn who is insured on the date of birth.

CRITICAL ILLNESS INSURANCE (IF APPLICABLE): Pre-existing Condition means: Any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by an Insured Person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of an Insured Person's coverage. **Pre-existing Condition Limitation:** No benefits will be paid if a Covered Critical Illness Condition results directly or indirectly from a Pre-Existing Condition. This limitation applies for the 24 months following the effective date of an Insured Person's coverage.

AUTHORIZATION

I hereby authorize MSH International (Canada) Ltd. ("MSH") or its representative(s) to release all medical information including but not limited to all diagnostic and treatment reports, test results and treatment recommendations to my family physician and/or attending Canadian physician(s). I also authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsurance company, government health insurance plan or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named minor children and other non-medical information of me or my named minor children, to give to MSH or its legal representative any and all such information. Any information obtained will not be released by MSH to any person or organization except to insuring or re-insuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that if I decide to add a newborn, foster, step or adopted child for immediate HealthSure™ coverage and such enrollment is not made within thirty-one (31) days from the date of birth or adoption, or within thirty one (31) days from the date I become legally responsible for a step or foster child, I will be required to submit an application (including evidence of insurability) satisfactory to MSH before the insurance is effective. In this case, my dependent Child's insurance is not effective until the date MSH specifies. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this signed authorization shall be valid as long as any claim under the Policy is outstanding.

PRIVACY AND CONFIDENTIALITY:

MSH International (Canada) Ltd. ("MSH") recognizes and respects every individual's right to privacy. When you apply for coverage or submit a claim, we establish a confidential file of personal information. We use the information to administer the individual benefit plan under which you are covered. This includes many tasks, such as: determining your eligibility for coverage, enrolling you for coverage, assessing your claims and providing you with payment, managing your claims, verifying and auditing eligibility and claims, Underwriting activities, such as determining the cost of the plan, analyzing the design options of the plan, and preparing regulatory reports, such as tax slips. We limit access to information in your file to MSH staff or persons authorized by MSH who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. MSH International (Canada) Ltd., your health care provider or other insurance and reinsurance companies may also exchange information when the information is needed to administer your HealthSure™ plan.

I confirm that:

- I have read and understand the **Pre-Existing Condition Limitations** contained in this application
- I understand that my HealthSure™ Premium coverage is conditional upon acceptance of my Application by MSH and will become effective in accordance with the Policy.
- I have read the above notice on **Privacy and Confidentiality** and consent to the collection, use and disclosure of my personal information (including personal information about my dependent(s)) required for enrolment and ongoing administration of the plan.
- **HealthSure™ Premium Applicants:** If I have applied for Critical Illness Insurance Non-Smoker rates, I confirm that I have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc.) within the last 12 months.

Applicant Signature (must always sign)	Applicant Name (Print)	Date Signed (MM/DD/YY)
Spouse's Signature (when applying)	Spouse's Name (Print)	Date Signed (MM/DD/YY)
Dependent's Signature (if 19 or over)	Dependent's Name (Print)	Date Signed (MM/DD/YY)
Dependent's Signature (if 19 or over)	Dependent's Name (Print)	Date Signed (MM/DD/YY)

FORM SUBMISSION INSTRUCTIONS: Submit this form to United Benefits Group Ltd. by email to kathys@accessbenefits.ca. Once we receive your form you will receive a confirmation phone call or email to the contact information you provided above. Note: We require a signature for each covered individual and a copy of photo ID. Please sign and ensure all required documents such as photo ID are included before submission.