ODY-max

ASSOCIATION PLAN

Extended Health, Travel and Dental coverage

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NOTICE

RECORDS AND PERSONAL INFORMATION

This notice applies to you, the insured, and to your spouse or dependent child for whom you have requested insurance.

For the purpose of administering your insurance plan, the insurer collects personal information about you and any other insured person. The insurer may retain the services of a specialized administrator to manage your insurance file as well as your claims.

In order to protect the confidentiality of your personal information, the insurer is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of the insurer or third parties acting on our behalf, in Canada or elsewhere, in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed. This personal information may be medical in nature or related to your lifestyle (driving record, pursuit of a hazardous sport, criminal record, etc.). When reviewing your insurance application or assessing a claim, we, our service providers or our reinsurers may consult any insurance file that we hold or that is held by other insurers or reinsurers with respect to any other insurance application or statement you may have made in the past. In the event of a claim, we may request a copy of your medical records.

If family coverage is involved, statements and claim cheques, which may contain personal information pertaining to your spouse of dependents, will automatically be sent to you as the plan member. You must therefore notify your family members that you will be receiving this personal information.

In the event of a claim, we may require a copy of your medical records. We could also retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your health, finances and lifestyle. In the course of this investigation, family members, friends and neighbors may be questioned about you. We may also require, on the event of a death claim, a copy of the police investigation report, coroner's report, or any other report that provides relevant information explaining the circumstances of your death.

Only those employees or agents (including any health care professional or pharmacist) who need the personal information for the performance of their duties will have access to your file. The insurer shall not communicate your personal information to a third party without your consent unless required to do so by law or ordered to do so by a court.

You are entitled to consult any personal information held in your file and, if applicable, to have it corrected by submitting a written request to the following address:

ASSOMPTION LIFE c/o Group Insurance Department
P.O. Box 160 / 770 Main Street
Moncton NB E1C 8L1
Tel.: 1-888-869-9797 Fax: 1-855-401-9068

CANASSURANCE Insurance Company
550, SHERBROOKE WEST ST
OFFICE B-9
MONTREAL (QUEBEC) H3A 3S3
Canada & U.S 1-833-243-2433
Other countries 514-370-2433

Give this copy to the proposed insured

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APPLICATION

☑ New enrolment ☐ Addition or Modification to existing policy ☐ Reinstatement **Contract No.:**

Name of Association : COHIP	Agent information	Code	%
Caldwell Insurance Services Ltd. Name of firm :	Name of agent 1 (administrator) : Brian D. McCreery	08103566	100
	Name of agent 2:		

1. RENSEIGNEMENT SUR L'ASSURÉ(E)

Agency:	Occupation :
First Name :	Last Name :

Date of Birth : _____ DD / MM / YYYY

Gender : ☐M ☐F

Language preference : ☐French ☐English

Address : _____
P.O. Box No. & Street Apt City Province Postal Code

Telephone : _____ _____ _____
Home Office Cell

E-mail : _____

2. CHOICE OF COVERAGE

Please choose between : ☐ Single ☐ Family ☐ Couple ☐ Single parent		**Monthly Premium $**
Extended health insurance	Plan 1 (Basic) Please complete all sections of this application, except for section 6	
	Plan 2 (Deluxe) Please complete all sections of this application	
	Plan 3 (Optinum) Please complete all sections of this application	
Travel Insurance		Included in EHC
Dental insurance	Plan 1 (Basic)	
	Plan 2 (Deluxe)	
Other		
	Total monthly premium	
	Total annual premium = (Total monthly premium x 12)	

ODY-max
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3. SPOUSE AND DEPENDANT CHILD* INFORMATION

Please note that the information of the insured persons must be indicated below.				Date of Birth		
	First Name	**Last Name**	**Gender**	**Day**	**Month**	**Year**
Spouse(1)			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			

(1) If common-law spouse, please specify the date cohabitation began (DD/MM/YYYY)_____/_____/_____.

***Dependent child** means an unmarried child of the insured (whether a natural child, a stepchild or an adopted child), of his or her spouse, or of both of them, who depends on the insured for his or her support and who:

1) Is older than 24 hours and younger than 21 years of age and does not work more than 20 hours a week, unless he or she is a full-time student;
2) Is 21 years of age or older but less than 26 if he or she is a regular full-time day student in a recognized academic institution; or
3) Regardless of age, has a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability must have begun while the child was considered a dependent as defined previously and be of such nature that the dependent is totally incapable of pursuing a gainful occupation.

****If the dependent child is over 21 years of age and a full-time student in a recognized academic institution please fill out the application for over-age dependency coverage.**

4. BANKING INFORMATION OR CLAIMS REIMBURSEMENT ONLY

(Please attach a blank cheque marked "**VOID**")

Name of Financial Institution:

Address of Financial Institution:

Insert the numbers found on the bottom of the cheque, as shown in the following example:

Branch number:	Financial Institution Number (Bank):	Account Number:

ODY-max
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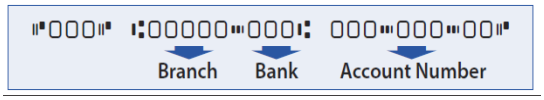
5. PREMIUMS AND METHOD OF PAYMENT

☐ **Monthly Pre-authorized debit $_____** (See Pre-authorised debit section)
Desired withdrawal date : the_____day of each month (**except 29th, 30th and 31st**)

☐ **Annual Pre-authorized debit $_____** (See Pre-authorised debit section)
The initial withdrawal date will be the same as the date of issue of the policy. Afterwards, the withdrawal date will be the same as the renewal date.

☐ **Annual $_____**
Make cheque payable to: « **Odyssey Insurance in Trust** », third party administrator on behalf of the insurer.

PREAUTHORIZED DEBIT (PAD) AGREEMENT

Banking Information	**Please attach a blank cheque marked « VOID »** **Name of Financial Institution :** _____ **Address of Financial Institution :** _____ _____ _____ **Name of payer :** _____ **Address of payer:** _____ _____ _____ **Branch Number :** _____-_____-_____-_____-_____ **Financial Institution Number :** _____-_____-_____ **Account number :** _____ 
Type of Service	☐ Personal – If debit is from a personal account ☐ Business – If debit is from a corporate account
Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.	1. I authorize the insurer, or his authorized representative, to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. 2. If a preauthorized debit is return due to insufficient funds (NSF) in the account, the insurer or his authorized representative, will withdraw the related $25 fee from that same account, without notice. 3. I agree to the debiting if my account on the regular preauthorized debit (PAD) withdrawal day as indicated on the application or the next business day (subject to change)
Waiver	**I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal***
Cancellation	You may cancel this preauthorized debit agreement at any time, subject to providing the insurer or his authorized representative with 10 days written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca)
Method of Payment	Any cancellation of this preauthorized debit agreement will not affect the agreement between you and the insurer whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	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
Exclusive Rights	All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance policy.

*The insurer or its authorized representative will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.

Date & Signature	_____ Date	_____ **Account Owner Signature**
	_____ Date	_____ **2nd Account Owner Signature (if applicable)**

ODY-max
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6. HEALTH QUESTIONS – FOR EXTENDED HEALTH PLAN 2 (DELUXE) AND PLAN 3 (OPTIMUM)

Any reference to test results, excludes genetic tests. Genetic test means a test that analyses DNA, RNA, or Chromosomes for purposes such as prediction of disease or vertical transmission risks. Do not provide any information about genetic tests in this application, other questionnaires or forms. However, you must answer all other questions truthfully including information about all other types of medical tests.

The insured, in his personal capacity as well as in his capacity of authorized representative of any insured person, hereby declaring that he/she and each insured person has not been diagnosed, hospitalized, treated, prescribed medication, or had any known indication of any of the following conditions during the past 12 months:

- AIDS (acquired immune deficiency syndrome), ARC (AIDS - related complex), tested positive on the AIDS virus antibody test or any other immunological disorder;
- High blood pressure, high cholesterol, arrhythmias, angina, heart attack, or any other heart or blood disorders;
- Ulcer, colitis, Crohn's disease, disorder of the stomach, pancreas, intestines or liver, including hepatitis B or C or any other gastrointestinal disorders;
- Anxiety, depression, chronic fatigue, autism, attention deficit hyperactivity disorder or a ny other mental, nervous or emotional disorder;
- Arthritis, amputation, fibromyalgia, chronic pain, back or neck disorders or any other bone or joint disorders;
- Acne, psoriasis or any other skin disorders;
- Chronic bladder infections, disorder of the kidneys, bladder, prostate or reproductive system;
- Alcohol or drug dependency;
- Diabetes (except gestational diabetes and you are not currently pregnant and diabetes has been ruled out);
- Sleep apnea, asthma, chronic bronchitis, chronic obstructive lung disease, emphysema or any other respiratory or lung disorders;
- Chronic headaches, migraine headaches, TIA (mini-stroke), stroke, seizures, paralysis, multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, amyotrophic lateral sclerosis (ALS) or any other neurological disorders;
- Cancer, tumor or leukemia;
- Any physical impairments, deformities or illnesses not covered above.

Signed at _____, on this day of _____ 20 ____.
(Province)

_____ _____

Signature of the proposed insured **Signature of the agent**

ODY-max
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7. DECLARATIONS, AUTHORIZATIONS AND SIGNATURE

On the date of signing of this application, the proposed insured, in his personal capacity as well as in his capacity of authorized representative of any proposed insured, hereby declares the following that concerning himself/herself and each eligible proposed insured:

- He/she is currently working or if not, he/she is not disabled or receiving any type of disability benefits.
- He/she is not currently hospitalized or waiting to be hospitalized (including day surgery).
- He/she has not been diagnosed or received any treatment (including medication) for any type of cancer in the past five (5) years (except for basal cell carcinoma).
- He/she has not tested positive on the AIDS virus antibody test or been diagnosed with AIDS (acquired immune deficiency syndrome) or ARC (AIDS – related complex). Initial ☐
- I confirm that each eligible proposed insured holds a valid card from his/her provincial health government plan.
- I attest to having received my dependent's consent (spouse and/or children) in order to enroll in this individual insurance plan in their name. (only applicable if you have requested coverage for your spouse and/or children)
- I confirm that the information and answers that I have provided in this document are true and complete.
- I attest to having received my spouse's consent, if applicable, in order to enroll in this insurance plan in his/her name. (Only applicable if you have requested coverage for your spouse and/or children).
- I confirm that the information and answers that I have provided are true and complete and acknowledge that they constitute the basis of my insurance coverage.
- I understand that if any answer is false or incomplete, any insurance coverage granted may be voided.
- I understand that I may be refused for insurance coverage if, in the opinion of the insurer, I am not insurable for the insurance coverage.
- I understand that any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date the insurer makes a decision must be reported to the insurer.
- I understand that if I fail to do so, any insurance coverage granted may be voided.
- I authorize any physician, healthcare professional, hospital, clinic, or other medical or paramedical establishment, as well as any insurance company, administrator of the insurance plan, administrator of a government program or any other benefits program or agency, institution or person that holds records or information pertaining to me or my health status, or pertaining to my children and their health status (when an insurance application on the life of a child is requested), to gather and exchange such records or information with the insurer or its reinsurers for underwriting and claims adjudication purposes. This information may be of a medical or other nature.
- In the event of a claim, I authorize any police force and any other agency that holds information regarding my claim to communicate such information to the insurer and its reinsurers.
- I have retained a copy of this document.
- I acknowledge that a copy of this authorization shall be as valid as the original.
- I authorize the insurer to deposit all my claim reimbursements to the designated bank account.
- I acknowledge receipt of the **Notice for records and personal information**.
- This authorization is valid for the purposes of this contract, its modification, its extension or its reinstatement.
- I acknowledge that a reproduction of this authorization shall be as valid as the original.
- I authorize the insurer or Odyssey Insurance (Groupe Financier Odyssée Inc) to use my personal information in order to send me information on other products and services that might interest me. If not, please check (√) the following

☐ I do not authorize this use.

Signed at _____, on this day of _____20___.
(Province)

_____ _____

Signature of the proposed insured **Signature of the agent**