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group benefits

Application for Extended Health Care, Dental and Journey Travel Plans

If you have any questions about the plan, need assistance completing your application form, or need to submit written notice of change or cancellation please contact the plan administrator, belairdirect at 1 833 749.1324.

1. Application Information please print clearly

First name	Last name	Gender
Address (including apartment/unit #)		Telephone #
City/Town	Province/Territory Postal code	Email address
Date of birth (dd/mm/yyyy)	Provincial health #	Name of group, association, or employer

2. Plan Information

Extended Health Care (EHC) Plan

I wish to enrol in the EHC plan: ☐ Yes ☐ No Indicate status of coverage required: ☐ Single ☐ Couple ☐ Family

I am enrolled in a pharmacare plan: ☐ Yes ☐ No

Prescription drug option (select one):

☐ Drug option A - $2,000 per household per calendar year ☐ Drug option B - $4,000 per household per calendar year

Note

- You must maintain enrolment in the EHC Plan for a minimum of 12 months. If your province or territory of residence has a pharmacare plan, these insurance coverages are only available if you are enrolled in the pharmacare plan.
- Once you enrol in Drug Option B, you must remain in the plan for 24 months.

Journey Travel Plan

I wish to enrol in the Journey travel plan: ☐ Yes ☐ No If "yes", check the appropriate boxes and complete the details below as required.

Base Plan (select one): ☐ 62-day base plan ☐ 93-day base plan

This insurance provides an unlimited number of trips within Canada of any duration, and an unlimited number of trips outside Canada of up to 62 or 93 consecutive days, depending on your base plan selection.

Deductible option (select one): ☐ No deductible ☐ $1,000 deductible (save 10% on base plan premiums)

Your deductible option can only be changed at the start of each new policy year, September 1st.

I wish to enrol in the **supplemental plan** ☐ Yes ☐ No

This plan is for a single trip of longer than 93 consecutive days outside of Canada, including the date you leave Canada for a period of more than 93 consecutive days and the date you return to your province or territory of residence.

Note: A 93-day **base plan** is required in order to purchase a **supplemental plan.**

Date of departure from Canada (dd/mm/yyyy): _____ Date of return to your home province or territory (dd/mm/yyyy): _____

Supplemental plan premiums are based on the total trip duration increments of

94-98, 99-107, 108-122, 123-137, 138-152, 153-167, 168-182, 183-197 and 198-212 days.

For example:

a trip of 99 days would have the same premium as a trip of 104 days, as the set premium for the total trip duration is in the range of 99 to 107 days.

Dental Plan

I wish to enrol in the dental plan (80% Basic, 80% Minor, 50% Major) ☐ Yes ☐ No

Indicate status of coverage required: ☐ Single ☐ Couple ☐ Family

Note: You must maintain enrolment in the dental plan for a minimum of 12 months.

Check here if you are maintaining other existing EHC coverage in addition to this plan: ☐ Yes ☐ No

If yes, are you the: ☐ Member or ☐ Spouse

Insurance company: _____ Policy #: _____

Important: You must complete and sign section 4 for coverage to be in force.

If you are not maintaining additional EHC coverage, when transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, you must provide the termination date (in space below). Coverage for this plan is effective the day after your or your spouse's plan terminates.

Termination date of your or your spouse's group benefits plan (dd/mm/yyyy): _____

Note:
- Those with existing group EHC benefits must apply within 60 days of losing existing employer coverage.
- After 60 days of prior plan termination, evidence of insurability is required.

If you have selected couple or family coverage, please provide spousal/dependent details below:

First name	Last name	Gender
Provincial health #	Date of birth (dd/mm/yyyy)	Dependents age 21+ ☐ full time student aged 24 or less ☐ disabled
First name	Last name	Gender
Provincial health #	Date of birth (dd/mm/yyyy)	Dependents age 21+ ☐ full time student aged 24 or less ☐ disabled

For additional dependents, please provide information on a separate page.

3. Monthly Premium Payment

☐ **Automatic bank withdrawal**. I authorize belairdirect, the plan administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5th deduction pays for September coverage. Due to application processing time, and the effective date of coverage, the initial deduction may cover up to 3 months of premium. I understand that my policy will be automatically cancelled should belairdirect receive two or more Non-Sufficient Funds (NSF) notices on my account.

☐ **Claim payment direct deposit**. I authorize belairdirect to deposit my extended health care (EHC) and dental claims reimbursements directly into my bank account.

☐ I have enclosed a sample cheque marked VOID to be used for automatic bank withdrawals and claims reimbursements.

4. Consent and Signature

I hereby certify that I am a Member in good standing with the sponsoring group, association, or employer ("Associate/Affiliate") and my eligibility ceases upon termination of my membership with such Association/Affiliate.

I acknowledge that to be eligible for insurance under the Extended Health Care (EHC) Plan, the Dental Plan and/or the Journey Travel Plan, I must: a) be a member, or a spouse or dependent of a member; b) be a Canadian resident; and c) be insured under my Provincial or Territorial Health Insurance Plan and I confirm that all persons listed on this application are eligible for the selected plan(s). I also acknowledge that the EHC Plan requires members to be enrolled in their provincial Pharmacare Program (if applicable).

I understand that EHC, Dental and Journey Travel Plan coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the first of the month following the date of receipt of application. If applying as a late applicant, I understand coverage will become effective the date the completed application is approved by the Insurer.

I also understand that unless I advise belairdirect Agency Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. belairdirect Agency Inc. will provide me with notification before the beginning of each subsequent policy year, which is September 1.

I authorize my "Association/Affiliate", my "Plan Administrator" belairdirect Agency Inc., my "Insurers" the Manufacturers Life Insurance Company and Belair Insurance Company Inc. (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application (the "Information"), for the purposes of the Extended Health Care Plan, Dental Plan and/or Journey Travel Plan (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). I authorize any person with Information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Association/Affiliate, for the Purposes. I understand that any coverage will not become effective until approved by the Providers. I authorize the use of my Provincial health number and any group member ID for the purposes of identification and administration. For further information on how Belair Insurance Company Inc. and belairdirect Agency Inc. manage your personal information, please visit: www.belairdirect.com/en/privacy.

☐ Please allow my spouse to contact belairdirect Agency Inc. to obtain any information regarding this insurance. I agree to allow belairdirect Agency Inc. to release and discuss any and all aspects as it pertains to our insurance.

I hereby certify that I have completed this application so that all statements made herein are true and correct in all respects and may be relied upon by Associate/Affiliate without further inquiry.

The Extended Health Care Plan and Dental Care Plan are underwritten by the Manufacturers Life Insurance Company ("Manulife") and administered by belairdirect Agency Inc. Coverage under the EHC Plan is subject to proof of enrolment in the applicable Provincial Pharmacare program. Valid provincial or territorial health plan coverage required. Journey Travel Plan is underwritten by Belair Insurance Company Inc. and administered by belairdirect Agency Inc. Valid provincial or territorial health plan coverage required. Belair Insurance Company Inc. and belairdirect Agency Inc. share common ownership. Travel assistance is provided by Global Excel Management Inc. Eligibility requirements, limitations and exclusions may apply and/or may vary by province or territory. Policy wordings prevail.

Signature of applicant	**Date** (dd/mm/yyyy)
Signature of spouse (if couple or family coverage selected)	**Date** (dd/mm/yyyy)

Please forward application to:

belairdirect Group Benefits Administration
PO Box 4005, Stn A
Toronto, ON M5W 0M7