

Application for Soloplus – Better or Best Programs

Available in all provinces except Quebec & Territories



APPLICANT INFORMATION

Applicant First Name		Applicant Last Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Height	Weight
Date of Birth (DD/MM/YYYY)		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Common Law <input type="checkbox"/> 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?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b)	Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c)	Diabetes, Colitis or Crohn's?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d)	Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e)	Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f)	Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g)	Infertility/Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h)	Chronic Headaches, Migraines, or recurrent infections?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i)	High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j)	Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney Disorder?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k)	Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
l)	Auto-Immune Disorders – Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
m)	Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
n)	Skin Disorder (including Acne)?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
o)	Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
p)	Other condition/Disease/Disorder/Injury – Please Specify: _____	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
q)	Are you currently receiving treatments, or have you consulted a Dental professional in the last 9 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
r)	Have you had any major Dental treatment within the last 5 years?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Are you currently taking, or have you been prescribed any prescription medications or discontinued a prescription in the last 3 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9.	Are you currently pregnant? If Yes, what is your expected due date? _____	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 for the Critical Illness Benefit.

Disability Benefits Accidental Death & Dismemberment Critical Illness: Requires a separate application form

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

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 <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Self Employed <input type="checkbox"/> Incorporated <input type="checkbox"/> 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:

- 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;
- To disclose only the necessary personal information, it has relating to me to these same persons and organizations, or as required by law;
- 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: