Corsana GROUP BENEFITS

Classic Coverage

Extended Health Care Coverage

	GUARANTEED		MEDICAL QUESTIONS ASKED
COVERAGE LEVEL	**Essential**	**Complete**	**Optimum**
Co-insurance	70%	80%	80%
Annual Plan Maximum	$5,000	$7,500	$10,000
Prescription Drugs	X	$2,5000	Unlimited (90%)
Travel Benefit	$1,000,000 (100%)	$1,000,000 (100%)	$1,000,000 (100%)
Hospital Accommodations	X	7 Day Max (100%)	14 Day Max (100%)
Private Duty Nursing/PSW	$1,500	$2,500	$5,000
Psychologist/Master of Social Work	$400 combined	$500 combined	$500 combined
Speech Therapist	$400	$500	$500
Physiotherapist	$400	$500	$500
Podiatrist/ Chiropodist	$400 combined	$500 combined	$500 combined
Massage/Chiropractor/ Osteopath/Naturopath/ Acupuncturist/Dietician/ Occupational Therapist	$400 combined	$500 combined	$500 combined
Vision	$100 Exam Not Incl. (100%)	$200 Exam Incl. (100%)	$250 Exam Incld. (100%)
Audio	$300	$500	$750
Accidental Dental	$1,500	$2,500	$5,000
Medical Items	$1,500	$2,500	Unlimited
Emergency Transportation	Unlimited (80%)	Unlimited	Unlimited
Medical Alert Bracelets	$50	$50	$50

Eligibility

- Over age 65
- Employee or retiree of an endorsing organization/ association
  OR
- Member of an endorsing organization/association

Benefits

- Extended health care benefits
- Optional dental care benefits

Trip Cancellation

- All Classic plans include trip cancellation coverage
- Benefit includes $5,000 at 100% coverage

Employee Assistance Program

- Access to an employee and family assistance program comes standard with all HCP plans

Dental Coverage

- Two optional plans to choose from
- No deductibles

Corsana GROUP BENEFITS

Classic Coverage

Rates (With And Without Drug Coverage)

Essential Coverage (No Drugs)

	Extended Health Care *(No Dental)*	Extended Health Care *including* **Basic Dental**	Extended Health Care *including* **Enhanced Dental**
Single	$65.10	$118.83	$142.19
Couple	$128.13	$224.71	$265.27
Family	$139.71	$289.19	$350.45

Complete & Optimum Coverage (With Drugs)

	Extended Health Care *(No Dental)*	Extended Health Care *including* **Basic Dental**	Extended Health Care *including* **Enhanced Dental**
Single	$122.53	$176.26	$199.62
Couple	$239.07	$335.65	$376.21
Family	$275.21	$424.69	$485.95

Basic Dental

- Co-insurance begins at 70% and increases to 80% in year two
- Overall coverage maximum starts at $500 in year one, increases to $750 in year two and $1000 in year three
- Includes 50% co-insurance for endodontic/peridontal services

Enhanced Dental

- 80% co-insurance
- Overall coverage maximum starts at $700 in year one, increases to $850 in year two and $1000 in year three
- Includes 80% co-insurance for endodontic/peridontal services
- Major restorative services are available after 36 consecutive months of dental coverage

1032 Brock Street S., Whitby, Ontario, L1N 4L8 | 1-855-267-7262 | info@corsana.com

GROUP ENROLLMENT FORM 1

TO PROCESS YOUR APPLICATION, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

Select a Plan:	☐ Prime	☐ Classic	
Select Dental Coverage:	☐ No Dental	☐ Basic Dental	☐ Enhanced Dental

If you are applying for couple or family coverage and one applicant is over age 65 and the other is not, simply tick all applicable boxes to indicate your coverage selections for both plans.

☐ I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)
☐ I wish to apply for the Essential level of coverage regardless of my guarantee (Classic only)

First Name: _____ **Last Name:** _____

Middle Initial: _____ **Date Of Birth** (MM/DD/YYYY)**:** _____ **Gender:** ☐ Female ☐ Male

Street Address: _____

Apt: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Email Address:** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law*

*Declaration For Common-Law Coverage

I the undersigned, hereby certify that I have been living with _____ since (MM/DD/YYYY) _____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

For Employees Of An Endorsing Organization Only

Date Hired (MM/DD/YYYY)**:** _____ **Occupation:** _____

Organization: _____ **Phone:** _____ **Ext:** _____

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

For Association Members Only

☐ Member of Association **Date Joined** (MM/DD/YYYY)**:** _____

Association: _____ **Phone:** _____ **Ext:** _____

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

Loss of Benefits (Complete Level of Coverage Only)

Are you currently covered under your spouse's or another group benefits plan? ☐ Yes ☐ No

Provided By: _____ **Insured Through:** _____

When does or did your benefits coverage end? (MM/DD/YYYY)**:** _____

Did you lose coverage while on any type of leave (maternity, disability, etc.)? ☐ Yes ☐ No

GROUP ENROLLMENT FORM 1

TO PROCESS YOUR APPLICATION, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

Request For Pre-Authorized Payment Plan (Mandatory For All Enrollments)

I hereby authorize Corsana Group Benefits to arrange automatic deductions from the following account:

Your Name As Shown On Your Account: _____

Name Of Financial Institution: _____

Street Address: _____

Unit:_____ **City:** _____ **Province:** _____ **Postal Code:** _____

Date (MM/DD/YYYY)**:** _____ **Signature:** _____

☐ **I'm applying for Classic and would like my monthly premium withdrawn on the first of the month**

Please note that we require **two cheques (NOT VOID)** to be submitted with your application and both must be made payable to **Corsana Group Benefits**. Please ensure that the cheques provided are drawn from the account listed above.
Your account must have chequing privileges

Enrollment Information For Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					
4th Child:					

Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Corsana Group Benefits for which I am eligible, and I authorize the association/organizationl to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependants must be covered under a provincial health plan and that I (retirees excluded) must be actively working in order to be eligible for coverage. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependants for whom coverage is sought. I understand that Corsana Group Benefits reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Corsana Group Benefits of any changes in my status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date (MM/DD/YYYY)**:** _____ **Signature of Applicant:** _____

STATEMENT OF HEALTH OPTIMUM COVERAGE

2

TO PROCESS YOUR APPLICATION, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

First Name: _____ **Last Name:** _____

Org/Assoc.: _____ **Occupation:** _____

General Information (Employee And Dependants)

Please complete the following information for all persons eligible for coverage including yourself, your spouse and all eligible dependants.

Relationship:	Name (First, Last):	Date Of Birth (MM/DD/YYYY):	Height (Ft/In):	Weigh (lbs):	Smoker (Y/N):
Employee:					
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					
4th Child:					

Statement Of Health Questionnaire

Have you or any of your dependants ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy, naturopathy, etc.) about, been treated for, or had any known indication of any of the following:

		Yes	No			Yes	No
1.	Circulatory, heart or vascular disease. High blood pressure, angina, stroke or TIA (mini stroke). Elevated cholesterol, chest pain or heart murmur?	☐	☐	2.	Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	☐	☐
3.	Arthritis, gout, rheumatism, osteoporosis/osteopenia. Disorder of joints, limbs or spine. Joint or muscle pain?	☐	☐	4.	Skin disorder including acne, rosacea, psoriasis or eczema?	☐	☐
5.	Colitis, Crohn's, irritable bowel syndrome (IBS), ulcers, hernia, reflux or persistent heart burn?	☐	☐	6.	Infertility, reproductive disorder, menopause, disorder of breasts, ovaries, cervix or uterus?	☐	☐
7.	Stomach, intestinal, kidney, bladder or liver disorder including hepatitis?	☐	☐	8.	Headaches, migraines, dizziness, fainting, disorder of the brain or nervous system?	☐	☐
9.	Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures, paralysis ADD or ADHD?	☐	☐	10.	Sexually transmitted disease (STD) or infection (STI) or recurring infections (including cold sores or herpes)?	☐	☐
11.	Alcohol or drug dependency?	☐	☐	12.	Diabetes or endocrine disorder?	☐	☐
13.	Lung condition, respiratory condition including COPD, asthma, allergies or sleep apnea?	☐	☐	14.	Disorder of the eyes, ears, nose or throat?	☐	☐
15.	Cancer, tumor or any other growth?	☐	☐	16.	Anemia or low iron?	☐	☐
17.	Have you or any of your dependants ever been treated or hospitalized for or had any known indication or any physical impairment, condition, disease or disorder not stated above?					☐	☐
18.	Are you or any of your dependants currently taking prescription or non-prescription medications of any kind or been advised by a physician or alternative health care provider to take medication of any kind?					☐	☐
19.	Have you or any of your dependants ever been advised to have an investigation, hospitalization or surgery which has not yet been completed?					☐	☐

If you answered yes to any of the questions above, please provide additional details on the overpage, and circle which diagnosis or disorder applies to you or your dependants.

STATEMENT OF HEALTH OPTIMUM COVERAGE

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Further Information Regarding Conditions From Overpage

If you answered yes to any of the questions on the overpage, please fill out the further details in the fields below and indicated the corresponding question number.

Question Number:	Name of Employee/Dependant (First, Last):	Injury or Condition:	Date of Onset & Recovery (MM/DD/YYYY):	Type of Medication or Treatment:	Approx. Monthly Cost of Medication:	How Often Do You See Your Doctor For Treatment:

Please note that based on your medical history, or that of a listed dependant, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the application which this statement of health is a part of.

Applicant Declaration

I hereby declare that all the statements contained in this application for the Corsana Group Benefits are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility, or organization which has records of my or my dependants health to release such information to the plan administrator. I understand and agree that the information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand that it is my obligation to inform Corsana Group Benefits of a change in my health or that of my spouse or any listed dependant children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Corsana Group Benefits reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Corsana Group Benefits reserves the right to audit claims. This form is valid ONLY 60 days from the date it is signed.

Dated _____ (City/Town) **this** _____ (Day) **day of** _____ (Month) **20** _____ (Year)

Signature of Applicant: _____

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Corsana Group Benefits is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

60-DAY OFFER FORM

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Complete Coverage Eligibility Statement

Please note that in order to be eligible for the GUARANTEED Complete level of coverage, you must be an employee, retiree or member of an endorsing Canadian association or organization.

New part-time and casual hires	Losing spousal benefits coverage
Full-time transferring to part-time or casual	Losing group benefits at age 65
Full-time transferring to temporary or contract	New association member
Full-time retiring	Full-time employee not covered for benefits
Full-time permanently laid-off	by the organization/association

You have 60 days from the first of the occurrences listed above to apply for the GUARANTEED Complete level of coverage for you, your spouse and eligible dependants. To confirm your eligibility for this 60-day offer under Corsana Group Benefits, you must submit with your application:

A copy of official documentation outlining your employment or membership status, retirement, or layoff and the start date of the occurrence.

– OR –

This 60-day offer form completed, signed and dated by an authorized personnel at your endorsing association or organization.

To Be Completed By Authorized Personnel Only

Employee Name: _____
(First Name/Last Name)

Endorsing Association/Organization: _____
(Organization/Association Name)

New Employee: **Start Date:** _____
(MM/DD/YYYY)

New Association Member: **Occurrence Date:** _____
(MM/DD/YYYY)

Loss Of Coverage:

☐ Retiring ☐ Permanently Laid Off ☐ Reaching @ Age 65

☐ Loss of spousal coverage

Occurrence Date: _____
(MM/DD/YYYY)

_____
(HR Initials)

By initialing, I certify that the above listed employee is losing their benefits after having been actively employed immediately prior to the occurrence dated above.

By signing and dating this 60-day offer form, I certify that the information detailed on this form regarding both the employee/member and corresponding information regarding their employment/ membership status with our association/organization is correct.

Authorized Personnel Name: _____
(Please Print)

Authorized Personnel Signature: _____
(Please Sign)