ENROLLMENT FORM – NEW PRIMARY

APPLICANT INFORMATION

Office Use Only **Open Window (Y/N)_____ Underwriting (Y/N) _____**

Check the box for the Plan 2 option you are applying for:

- ☐ Complete Level of Extended Health Care with Drugs
- ☐ Complete Level of Extended Health Care with Drugs & Basic Dental
- ☐ Complete Level of Extended Health Care with Drugs & Enhanced Dental

LAST NAME_____ **FIRST NAME**_____ **MIDDLE INITIAL** _____

_____/_____/_____/_____
HOME MAILING ADDRESS **CITY** **PROVINCE** **POSTAL CODE**

HOME PHONE NUMBER (_____)_____ **EMAIL ADDRESS** _____

MALE ☐ **FEMALE** ☐ **DATE OF BIRTH (dd/mm/yyyy)**_____/_____/ _____ **SMOKER (Y/N)** _____

Please provide the following information regarding your current or recently ended group coverage with the Health Care Providers Group Insurance Plan:

Plan Holder's Name_____ Relationship to you _____

Plan Holder's Hospital Site_____ Last day you were covered (dd/mm/yyyy) ___/___/ _____

Reason existing or prior coverage ended _____

Please indicate your current status:

Single ☐ **Widowed** ☐
Married ☐ **Separated** ☐
Divorced ☐ **Common Law *** ☐

* I the undersigned, hereby certify that I have been living with _____

since (dd/mm/yyyy) _____/_____/_____/ and representing him / her as my spouse or my (common-law) spouse.

DO YOU HAVE DEPENDENTS ELIGIBLE FOR COVERAGE UNDER THIS PLAN? NO ☐ **YES** ☐ **(IF "YES" FILL OUT CHART BELOW)**

DEPENDENTS ENROLLMENT INFORMATION

Dependents	Surname	First Name	M/F	DOB dd/mm/yyyy
Spouse				
1st Child				
2nd Child				
3rd Child				
4th Child				

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REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN

I hereby authorize Health Care Providers to arrange automatic deductions from the following account:
YOUR ACCOUNT MUST HAVE CHEQUING PRIVILEGES

Your name as shown on the account: _____

Name of your Bank: _____

Address of Bank: _____ City: _____ Postal Code: _____

Date: (dd/mm/yyyy) _____ Signature: **X** _____

Two (2) cheques are required with your application; please make them both payable to **HCP Group Insurance Plan.** Also, please ensure that these 2 cheques are drawn on the account from which you wish us to withdraw your monthly premium.

I hereby apply for benefit coverage from the Health Care Providers Group Insurance Plan™ for which I am eligible I acknowledge all information is complete and accurate.
I understand that I and my dependents must be covered under my Provincial Health Plan in order to be eligible for Extended Health coverage. I understand that the Health evidence provided on myself and my dependents as part of this application may be used by all parties involved in the issuing of my coverage. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.

Acknowledgment
I understand coverage is effective on the first of the month following the date I apply, unless I elect to delay the effective date one month.

Provided all of the following requirements have been met:

- A fully completed signed application and required premium has been received by the Health Care Providers Group Insurance Plan, c/o Hardiman Mount & Associates Insurance Brokers Limited
- Underwriting approval (when underwriting is required)
- I continue to meet all eligibility rules

Date: (dd/mm/yyyy) _____ Signature of Applicant **X** _____

Privacy Statement

Hardiman Mount & Associates Insurance Brokers Limited 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.