ContinYou™

JG25-CY

APPLICATION FORM

Office Use Only
Eligibility confirmed ❑
Effective date of coverage _____
Certificate number _____

General Information

Applicant's Last Name _____ First Name _____ Initial _____

Address _____

City _____ Province _____ Postal Code _____

Phone (_____) _____ E-mail _____

Language of preference: ❑ English ❑ French

Please indicate the current/previous Chambers of Commerce Group Insurance Plan, Maximum Benefit, CINUP or Johnston Group plan you were covered under:

Firm Name _____

Firm # _____ Certificate # _____ Date coverage ended (YY/MM/DD) _____

Plan Choice

I/We apply for ContinYou coverage: ❑ Base ❑ Enhanced ❑ Enhanced Plus

I/We understand we must maintain this coverage for at least two years before I/We can change my/our benefits and changes can only be done on the anniversary date of my/our policy.

Individuals covered under the above group Health and Dental plan are eligible for ContinYou coverage. I/We are applying for coverage for
❑ Myself ❑ Myself AND my spouse ❑ Myself AND my dependents ❑ Myself AND my spouse AND my dependents

When coverage under ContinYou is provided for a spouse whose survivor benefits have ended, or a dependent child who no longer satisfies the definition of an eligible dependent due to their age, they will be considered the "applicant".

If dependent coverage is desired, eligible dependents MUST be added at the time of the *Applicant's* application.

	First & Last Name	Gender (M/F)	Date of Birth YY/MM/DD
Applicant			
Spouse			
Dependent Child*			
Dependent Child*			
Dependent Child*			
Dependent Child*			

***Overage students** must complete a Request for Overage Dependent Coverage. **Incapacitated overage dependents** must complete a Request for Overage Disabled Dependent Coverage prior to reaching the maximum dependent age for consideration of coverage. These forms are available at www.johnstongroup.ca/en/resources/resources.html

PLEASE COMPLETE THE INFORMATION ON NEXT PAGE

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APPLICATION FORM (CONTINUED)

Though your coverage is guaranteed, you may be eligible for discounted rates. Should you wish to provide evidence of good health in order to be eligible for discounted rates, complete this Health Declaration section.

Health Declaration (All questions must be completed)

Please check box if any person for whom application is being made (including yourself, spouse and dependents) has been advised, counseled, tested, diagnosed, treated, hospitalized, or recommended for treatment within the last 5 years for the following: (If you answer "YES" to any question, please circle the condition to which you are referring.)

APPLICANT

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

SPOUSE

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

CHILD

Full name and address of personal physician _____

Date of last consultation _____ Reason _____

Height _____ Weight _____

		APPLICANT	SPOUSE	CHILD
1.	Do you or any of your dependents have any physical defect or infirmity?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2.	Have you or any of your dependents suffered from any recurring illness or injury, whether or not medical attention was sought?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3.	Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4.	Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Details to Health History (Give details on each item checked "Yes" above)

Question Number	Person Affected	Condition/ Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates From / To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

PLEASE COMPLETE THE INFORMATION ON NEXT PAGE

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APPLICATION FORM (CONTINUED)

Payment of Premium

I enclose a cheque for the initial premium of $ _____ payable to Johnston Group Inc. which represents the premium amount for one month of coverage based on my age, province of residence, and dependents to be covered under this plan.

I authorize Johnston Group to debit the account below on the 1st day of each month. **I have attached a second cheque, marked "VOID"** to verify the necessary bank account details. The monthly debit is for group insurance premium. The amount may be variable and I will receive notice of the debit by mail approximately 3 business days before the 1st of each month. However, I will not receive notice of subsequent months' debits until such time as the amount changes.

I understand that this agreement may be revoked at any time by providing 30 days written notice. I understand that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. I understand that I may obtain further information on my right to cancel / recourse rights by contacting my financial institution, or by visiting www.cdnpay.ca.

BANK ACCOUNT INFORMATION

Account # _____ Transit # _____

Bank Name _____

Branch Address _____

I authorize Johnston Group to make withdrawals for the payment of monthly premiums.

Authorized Signature _____ Date _____

The account you choose must have chequing privileges.

Request for Direct Deposit of Extended Health and Dental Claims

I hereby authorize Johnston Group Inc. to make a direct deposit of my benefit payment(s) to:

❑ the same chequing account shown on attached 'Void' cheque, or
❑ to a different chequing account indicated below:

Bank _____

Address _____ City _____ Province _____

To ensure we accurately encode all the necessary information, please enclose a sample cheque marked "Void – Direct Deposit".

PLEASE COMPLETE THE INFORMATION ON NEXT PAGE

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APPLICATION FORM (CONTINUED)

Declaration & Authorization

I/WE hereby apply for Group Benefit Conversion Coverage. I/WE certify that the information provided herein is true, accurate and complete; and that I am or have been covered under a group health and dental plan indicated above within the last 60 days. I understand that I and my dependents must currently be covered under my Provincial Health plan and remain covered in order to be eligible for coverage. I/WE agree that any coverage issued in consequence of this application shall not become effective until the application is approved.

I authorize The Co-operators, Johnston Group Inc., their advisors and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents, including health professionals, institutions, insurers and reinsurers. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. A photocopy of this authorization is as valid as the original and shall remain in effect throughout the duration of my coverage under this benefit plan.

Applicant's Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____

Please return the completed application and first month's premium to:

ContinYou
National Service Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4

Co-operators Life Insurance Company and Johnston Group Inc. are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that they collect, use, retain and disclose in the course of conducting business.

Underwritten by The Co-operators. Administered by Johnston Group Inc.

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