ContinYou™

JG25-CY

APPLICATION FORM

Office Use Only
Eligibility confirmed ❑
Effective date of coverage ______________________
Certificate # ______________________

General Information

Applicant's Last Name ______________________ First Name ______________________ Initial ________

Address ______________________

City ______________________ Province __________ Postal Code __________

Phone (______) ______________ Email ______________________

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

ContinYou coverage I'm applying for ❑ Base ❑ Enhanced ❑ Enhanced Plus

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

Individuals covered under the above group Health and Dental plan are eligible for ContinYou coverage. I am 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*			

***Over-age students** must complete a *Request for Over-age Dependent Coverage.* **Incapacitated over-age dependents** must complete a *Request for Over-age 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

APPLICATION FORM (CONTINUED)

Payment of Premium

I authorize Johnston Group to debit the account below on the 1st day of each month. **I have attached a 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

APPLICATION FORM (CONTINUED)

Declaration & Authorization

I hereby apply for Group Benefit Conversion Coverage. I 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 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 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 ____________________

Please return the completed application to:

ContinYou
National Service Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4
continyou@johnstongroup.ca

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