INNOVATIVE BUSINESS CLUB

PRIVATE & CONFIDENTIAL

For Office Use Only: *Contract Ref. Code:* ***IBC-*** *Approval Date:* _____, *Approved By:* _____ *GS ID Number:* _____

Part A

Plan Choice

You, your spouse/partner and all listed dependents must have Provincial Government Health Care coverage.

Applicant
Last Name: **First Name:** **Applying For:** ❑ **Single** ❑ **Couple** ❑ **Family**

❑ **Drug, EHS, Dental, Travel** ❑ **Drug, EHS, Travel** ❑ **Drug, EHS, Vision, Semi-private, Dental, Travel**

Part B

Dependent children must be under Age 21

please print clearly

Last Name of any family member if different from the Applicant **Last Name**	First Name and Middle Initial of all family members applying **First Name** **Initial**	**Sex** [M/F]	Date of Birth **YYYY**	**MM**	**DD**	**Age**
Applicant						
Spouse/Partner						
Dependent Child						
Dependent Child						
Dependent Child						

Part C

Mailing address

Last Name First Name Initial

Apt. No. Street Address

City or Town Prov. Postal Code

Home Telephone ( ) Business Telephone ( )

Part D

Prescription drug information

Missing information will delay the processing of your application

Prescription drugs include oral medications, injectables, creams, drops, serums and birth control

For all those listed in Part B are there any prescription drugs for which refills are currently authorized ❑ YES ❑ NO

If you answered "YES" to this question, please give details below [if additional space is required, please attach a separate sheet]

Name of Person	Name of drug / medication/serum/cream	Monthly cost of drug/medication / serum/cream	Strength of drug/medication/ serum/cream	Daily Dosage of drug/medication/ serum/cream	Length of Time on this drug/medication/ serum/cream
		$			
		$			
		$			
		$			

Part E

Statement of health for applicant/spouse/partner and dependent children

1 Has anyone been hospitalized in the last two years?

Applicant : ❑ YES ❑ NO Spouse/Partner : ❑ YES ❑ NO Dependent Children : ❑ YES ❑ NO

2 Does anyone expect to be hospitalized in the next three months ?

Applicant : ❑ YES ❑ NO Spouse/Partner : ❑ YES ❑ NO Dependent Children : ❑ YES ❑ NO

If you answered "YES" to question 1 or 2 , please give details below [if additional space is required, please attach a separate sheet]

Name of Person	Date of Illness, Injury or Confinement	Number of days in hospital or anticipated number of days in hospital	Details of Illness or Injury

Part E (continued…)

3. Have you, your spouse/partner or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist about any of the following conditions? Please Check ✓ **Yes or No** for all questions and **circle** the specific medical condition, if applicable.

	Applicant	SPOUSE / PARTNER	DEPENDENT(S)
• alzheimer's, anxiety, dementia, depression, emotional disorder, paralysis, parkinson's or seizures	__ YES __ NO	__ YES __ NO	__ YES __ NO
• ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)	__ YES __ NO	__ YES __ NO	__ YES __ NO
• stomach, intestinal, kidney, bladder or liver disorder including hepatitis	__ YES __ NO	__ YES __ NO	__ YES __ NO
• infertility, reproductive disorder or menopause	__ YES __ NO	__ YES __ NO	__ YES __ NO
• colitis, crohn's, hernia, irritable bowel syndrome, persistent heartburn, reflux or ulcers	__ YES __ NO	__ YES __ NO	__ YES __ NO
• angina, circulatory, heart or vascular disease, high blood pressure, , stroke or TIA (mini-stroke)	__ YES __ NO	__ YES __ NO	__ YES __ NO
• elevated cholesterol	__ YES __ NO	__ YES __ NO	__ YES __ NO
• alcoholism or drug dependency	__ YES __ NO	__ YES __ NO	__ YES __ NO
• skin disorders including acne, eczema, psoriasis or rosacea	__ YES __ NO	__ YES __ NO	__ YES __ NO
• AIDS, ARC (AIDS related complex), HIV or other immunological disorder	__ YES __ NO	__ YES __ NO	__ YES __ NO
• arthritis/rheumatism, osteoporosis, bone density loss, back, joint or muscle pain	__ YES __ NO	__ YES __ NO	__ YES __ NO
• allergies or asthma, lung or respiratory conditions including COPD	__ YES __ NO	__ YES __ NO	__ YES __ NO
• headaches or migraines	__ YES __ NO	__ YES __ NO	__ YES __ NO
• cancer, leukemia or tumor	__ YES __ NO	__ YES __ NO	__ YES __ NO
• diabetes, endocrine, hormonal or thyroid disorder	__ YES __ NO	__ YES __ NO	__ YES __ NO
• sexually transmitted diseases (STDs or STIs)or recurring infections such as cold sores or herpes	__ YES __ NO	__ YES __ NO	__ YES __ NO
• glaucoma	__ YES __ NO	__ YES __ NO	__ YES __ NO
• any other condition/disease/disorder or injury not listed above. If yes, please specify:	__ YES __ NO	__ YES __ NO	__ YES __ NO

If you answered "YES" to any of the conditions in Question 3, please give details below [if additional space is required, please attach a separate sheet]

Name of Person	Diagnosis	Date of Diagnosis	Drugs and/or Treatment	Last Prescription filled and/or Treatment Date
		yyyy/mm		yyyy/mm
		yyyy/mm		yyyy/mm
		yyyy/mm		yyyy/mm

Part F

Authorization must be signed by the Applicant and Spouse/Partner (if applicable)

NOTE: The information provided on this form is confidential.

By signing this application form, I/we agree that the statements contained herein are true and complete, to the best of my/our knowledge and form the basis for any coverage approved. I am authorized to release information concerning my spouse/partner and all listed dependent children, for the purposes of determining eligibility for benefits. Failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependent children could result in denial of a claim and the cancellation or modification of this coverage.

I/We understand that it is my/our obligation to inform Innovative Business Club / Green Shield Canada of a change in my health and that of my spouse/partner and any listed dependent children due to either injury or illness which occurs after the date of application and prior to the effective date of the policy. I/We understand that the coverage shall not become effective until the first of the month following approval by Innovative Business Club / Green Shield Canada. I/We authorize any physician, dentist, medical practitioner, hospital, clinic or other medical or medical related facility, insurance company, or other organization, institution or person that has any records or knowledge of my health, and that of my spouse/partner and any listed dependent children, to exchange any such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Green Shield Canada. A reproduction of this consent and authorization shall be as valid as the original.

Signature of Applicant ***X*** Date: YYYY MM DD

Signature of Spouse/Partner ***X*** Date: YYYY MM DD

GSC's commitment to privacy

Your personal information is collected for the purpose of providing you with health and dental benefits, claims analysis and payment. For information on Green Shield Canada's privacy policies and procedures, visit greenshield.ca.

General Information

MEMBERSHIP
Your application cannot be processed unless you are a member of the Innovative Business Club.

To keep your policy in force, you must continue to be a member of the Innovative Business Club.

PLAN ADMINISTRATORS
Countrywide Benefit Administrators, 676 Monarch Ave, Unit 13, Ajax, ON L1S 4S2

NOTICE OF PRIVACY AND CONFIDENTIALITY
The Innovative Business Club and Countrywide Administrators will collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. To protect its confidentiality, access to this information will be restricted to those administrators who are responsible for administration of services, underwriting, marketing, and for the processing, facilitating and investigation of claims. When necessary, this information may be shared with others such as, but not limited to, medical facilities, insurance companies, organizations, and to any other person you authorize or that is authorized by law. This acknowledges that information may be transmitted by facsimile (fax), e-mail, postal service, courier service or telephone, and we cannot guarantee the security or privacy of the information that is transmitted through these channels. Call us at 905-686-3320 for a copy of our Privacy Statement.

PRE-AUTHORIZED PAYMENT

Please make cheque payable to: **"Innovative Business Club"**

Note: **Applications cannot be processed without the 1st month's payment PLUS one of the account holder's cheques marked "Void".**

Monthly Premium $_____

I hereby authorize Innovative Business Club **to withdraw premium payments from my account thirty (30) days in advance of the due date,** on or about the first business day of each month. Should there be any change in either the amount or premium due date, Innovative Business Club will give me written notice of at least thirty (30) days in advance. Innovative Business Club may terminate coverage should a withdrawal be refused for any reason and the financial institution shall be in no way held liable should such an event occur. **The authorization shall remain valid unless written notice is received by Innovative Business Club, ten (10) business days prior to the next pre-authorized debit due date** requesting cancellation by the account holder(s).

Signature of Account Holder ***X*** _____ Date: _____

2nd Signature if Joint Account ***X*** _____ Date: _____

Please send the completed application and cheques to:

Innovative Business Club
676 Monarch Avenue, Unit #13
Ajax, ON L1S 4S2
Tel: 905-686-3320 / 1-800-267-7781

_____

Broker Name (please print)