GSC healthassist®

ZONE

Benefit & Coverage Details

Individual Health & Dental Plans

GSC Health Assist ZONE plans offer varying levels of health, dental, drug and travel coverage in a selection of bundled plans – at competitive prices.

Time to ZONE in on the plan that's right for you…

If you do not currently have a health plan...

You know there are gaps in provincial health insurance plan coverage.

GSC Health Assist ZONE® plans provide coverage against the day-to-day, routine medical and dental expenses not covered by your provincial plan, as well emergency medical travel protection when you're away from home, plus coverage for unforeseen health expenses that may arise in the future.

This Plan Comparison presents the benefits and coverage each ZONE plan offers.

Here's a description of some of the key ZONE benefits...

PRESCRIPTION DRUGS

Prescription drug benefits cover prescription drugs approved for use in Canada that require a prescription by law and have been prescribed by an authorized medical practitioner.

Brand name drugs are covered if no generic equivalent exists.

Smoking cessation products and drugs for the treatment of obesity, infertility and erectile dysfunction are not covered.

DENTAL CARE

BASIC SERVICES:

- Preventive cleaning
- Routine examinations, x-rays
- Fillings and extractions
- Fluoride treatment for children

COMPREHENSIVE BASIC SERVICES:

- Endodontic treatment – root canal therapy
- Periodontal treatment – scaling and root planing, occlusal adjustment, equilibration
- Denture repairs, rebasing, relining

MAJOR SERVICES:

- Crowns and onlays, dentures, bridgework

ORTHODONTIC SERVICES:

- Orthodontic treatment to straighten teeth and correct the bite

EXTENDED HEALTH CARE

MEDICAL ITEMS:

- Aids for daily living (such as hospital style beds, IV stand, trapeze, bedpan)
- Braces, casts, catheters and ostomy supplies
- Compression stockings
- Diabetic supplies
- Custom made boots or shoes, custom made foot orthotics
- Mobility aids (such as canes, crutches, walkers, wheelchairs)
- Prosthetics
- Respiratory/cardiology items (such as breathing and heart monitors for infants, compressors, oxygen)

EMERGENCY MEDICAL TRAVEL COVERAGE

Emergency medical coverage when travelling out-of-province or out-of-country

OPTIONAL HOSPITAL ACCOMMODATION

Semi-private and/or private accommodation in a public general hospital

Benefits effective April 1, 2020	No Medical Underwriting Required — Your Acceptance is Guaranteed			
	ZONE Plan 1	**ZONE Plan 2**	**ZONE Plan 3**	**ZONE Fundamental Plan**
PRESCRIPTION DRUGS (benefits per person)				
Maximums	Not included	Not included	Not included	Year 1: $550 Year 2: $600 Year 3+: $650 Plan pays 70% to annual max.
DENTAL CARE (benefits per person)				
Maximums	Not included	Year 1: $500 Year 2: $650 Year 3+: $800	Year 1: $600 Year 2: $800 Year 3+: $1,000	$450 per year
Recall Frequency		9 months	9 months	9 months
Basic Services		Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.	Plan pays 70%, subject to annual max.
Comprehensive Basic Services		Year 1: Plan pays 50% Year 2: Plan pays 70% Year 3+: Plan pays 80% subject to annual max.	Plan pays 80%, subject to annual max.	Plan pays 70%, subject to annual max.
Major Services		Not included	Available in Year 3 - Plan pays 50%, subject to annual max.	Not included
Orthodontic Services		Not included	Not included	Not included
VISION CARE (benefits per person)				
Vision Care Prescription eyeglasses, contact lenses, laser eye surgery	$150 every 2 years	$150 every 2 years	$150 every 2 years	$150 every 2 years
Eye Examination	$65 every 2 years	$65 every 2 years	$65 every 2 years	$80 every 2 years
EXTENDED HEALTH CARE (benefits per person)				
Professional Services/Registered Therapists				
Acupuncturist, Chiropractor, Chiropodist/Podiatrist, Massage Therapist, Naturopath, Osteopath, Physiotherapist	$20 per visit to a max. of $300 per practitioner, per year	$20 per visit to a max. of $300 per practitioner, per year	$20 per visit to a max. of $400 per practitioner, per year	$20 per visit to a max. of $400 per practitioner, per year
Psychologist/Registered Social Worker, Speech Therapist	$300 per practitioner, per year	$300 per practitioner, per year	$400 per practitioner, per year	$400 per practitioner, per year
Accidental Dental	$5,000 per year	$5,000 per year	$5,000 per year	$3,000 per year
Ambulance Transportation	Includes land and air	Includes land and air	Includes land and air	Includes land and air
Hearing Aids	Year 1-4: $300 Year 5+: $400 every 4 years	Year 1-4: $300 Year 5+: $400 every 4 years	Year 1-4: $350 Year 5+: $500 every 4 years	Year 1-4: $350 Year 5+: $500 every 4 years
Medical Services Diagnostic tests and x-rays, dialysis equipment, laboratory tests	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
Medical Items and Home Support Services (in home nursing) Separate maximums for Medical Items and Home Support Services	Year 1: $1,000 Year 2: $1,500 Year 3: $2,000 Year 4+: $2,500 per benefit category, per year	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per benefit category, per year	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per benefit category, per year	Year 1: $1,500 Year 2: $2,000 Year 3: $3,000 Year 4+: $4,000 per benefit category, per year
TRAVEL (benefits per person) Out of Province/Country				
Emergency Medical Travel Coverage	15 days per trip; $5,000,000 per year	15 days per trip; $5,000,000 per year	15 days per trip; $5,000,000 per year	15 days per trip; $5,000,000 per year
OPTIONAL HOSPITAL ACCOMMODATION (benefits per person) Optional benefit pays for the difference in cost between standard ward charges and Semi-Private and/or Private accommodation in a public general hospital. Medical underwriting is required.				
Semi-Private and/or Private	Up to 30 days per year	Up to 30 days per year	Up to 30 days per year	Up to 30 days per year

Benefits effective April 1, 2020	Medical Underwriting Required			
	ZONE Plan 4	**ZONE Plan 5**	**ZONE Plan 6**	**ZONE Plan 7**
PRESCRIPTION DRUGS (benefits per person)				
Maximums	Year 1-2: $2,500 } Plan pays 80% Year 3+: $3,500 } to annual max.	$5,000 Plan pays 90% to annual max.	$10,000 Plan pays 90% to annual max.	$20,000 Plan pays 90% to annual max.
DENTAL CARE (benefits per person)				
Maximums	Not included	Year 1: $700 Year 2: $900 Year 3+: $1,100	Year 1: $800 Year 2: $1,000 Year 3+: $1,300	Year 1: $1,000 Year 2: $1,200 Year 3+: $1,500
Recall Frequency		9 months	6 months	6 months
Basic Services		Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.	Year 1: Plan pays 80%, subject to annual max. Year 2+: Plan pays 90%, subject to annual max.
Comprehensive Basic Services		Year 1: Plan pays 60% Year 2: Plan pays 70% Year 3+: Plan pays 80% subject to annual max.	Plan pays 80%, subject to annual max.	
Major Services		Available in Year 3 - Plan pays 50%, subject to annual max.	Available in Year 3 - Plan pays 50%, subject to annual max.	Available in Year 3 - Plan pays 50%, subject to annual max.
Orthodontic Services		Not included	Available in Year 3 - Plan pays 50% subject to Year 3+ annual max. and $2,000 lifetime max.	Available in Year 3 - Plan pays 50% subject to Year 3+ annual max. and $2,000 lifetime max.
VISION CARE (benefits per person)				
Vision Care Prescription eyeglasses, contact lenses, laser eye surgery	$150 every 2 years	Year 1-2: $150 Year 3-4: $200 Year 5+: $250 every 2 years	Year 1-2: $200 Year 3-4: $250 Year 5+: $300 every 2 years	Year 1-2: $250 Year 3-4: $300 Year 5+: $350 every 2 years
Eye Examination	$80 every 2 years	$100 every 2 years	$100 every 2 years	$120 every 2 years
EXTENDED HEALTH CARE (benefits per person)				
Professional Services/Registered Therapists				
Acupuncturist, Chiropractor, Chiropodist/Podiatrist, Massage Therapist, Naturopath, Osteopath, Physiotherapist	$20 per visit to a max. of $400 per practitioner, per year	$25 per visit to a max. of $500 per practitioner, per year	$25 per visit to a max. of $600 per practitioner, per year	$50 per visit to a max. of $750 per practitioner; $2,000 combined per year
Psychologist/Registered Social Worker, Speech Therapist	$400 per practitioner, per year	$500 per practitioner, per year	$600 per practitioner, per year	$750 per practitioner, per year
Accidental Dental	$5,000 per year	$10,000 per year	$10,000 per year	$15,000 per year
Ambulance Transportation	Includes land and air	Includes land and air	Includes land and air	Includes land and air
Hearing Aids	Year 1-4: $350 Year 5+: $500 every 4 years	$500 every 4 years	$500 every 4 years	$600 every 4 years
Medical Services Diagnostic tests and x-rays, dialysis equipment, laboratory tests	$2,000 per year	$2,000 per year	$2,000 per year	$2,500 per year
Medical Items and Home Support Services (in home nursing) Separate maximums for Medical Items and Home Support Services	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 } per benefit category, per year	Year 1: $2,000 Year 2: $4,000 Year 3+: $6,000 } per benefit category, per year	Year 1: $2,000 Year 2: $4,000 Year 3+: $6,000 } per benefit category, per year	Year 1: $3,000 Year 2: $5,000 Year 3+: $8,000 } per benefit category, per year
TRAVEL (benefits per person) Out of Province/Country				
Emergency Medical Travel Coverage	15 days per trip; $5,000,000 per year	30 days per trip; $5,000,000 per year	30 days per trip; $5,000,000 per year	30 days per trip; $5,000,000 per year
OPTIONAL HOSPITAL ACCOMMODATION (benefits per person) Optional benefit pays for the difference in cost between standard ward charges and Semi-Private and/or Private accommodation in a public general hospital. Medical underwriting is required.				
Semi-Private and/or Private	Up to 30 days per year	Up to 30 days per year	Up to 30 days per year	Up to 30 days per year

Additional information

This Plan Comparison is a summary and does not constitute a contract. Actual terms, conditions, limitations and exclusions are detailed in the contract issued by GSC upon application approval.

Reimbursement will be made for eligible expenses incurred, paid for and received by the covered person provided such services and supplies are, in the opinion of GSC, medically necessary for the treatment of an illness or injury and reasonable and customary, taking all factors into account.

Quebec residents: To be eligible for ZONE prescription drug coverage, you must be covered by the RAMQ prescription drug plan. Your prescription drug claims must be submitted to RAMQ first. When RAMQ reimburses a portion of the drug cost, the unpaid balance (including co-payment and deductible) will be co-ordinated so that you may be reimbursed up to 100% of the eligible expense incurred. If the drug is not covered by RAMQ, the standard co-pay applies.

Coverage amounts shown are in Canadian Dollars.

Rates and/or benefits are subject to change; GSC will provide plan members with thirty (30) days written notice.

Plans provided by

Green Shield Canada (GSC).

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Green Shield Canada, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1

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gsc healthassist®

ZONE

Rates

Individual Health & Dental Plans

GSC Health Assist ZONE plans offer varying levels of health, dental, drug and travel coverage in a selection of bundled plans – at competitive prices.

Time to ZONE in on the plan that's right for you…

ZONE plans equal valuable coverage at competitive prices

GSC Health Assist ZONE® plans are designed to cover the gaps in your provincial health insurance plan. And provincial plans differ a little from province to province.

That's why ZONE rates vary a bit depending on where you live.

There are three ZONE rate categories.

And so there's no mystery – here are the definitions…

Single: applies to the applicant only.

Couple: applies to the applicant and spouse/partner

OR the applicant and one dependent child under age 21.

Family: applies to the applicant and spouse/partner and dependent children under age 21.

Some additional details to note…

Rates are effective April 1, 2020.

Rates and/or benefits are subject to change; GSC will provide plan members with thirty (30) days written notice.

Rates are based on age of the primary applicant at the time of application.

Rates will increase as an individual's age increases in accordance with published age bands.

Effective April 1, 2020
Monthly Rates
for Residents of:

British Columbia

AGE	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$26	$48	$61	$78	$146	$191	$84	$159	$207	$86	$153	$224
45 - 54	$27	$50	$65	$79	$150	$195	$85	$161	$210	$103	$184	$263
55 - 59	$29	$54	$67	$81	$153	$199	$86	$163	$213	$108	$193	$280
60 - 64	$30	$57	$73	$83	$154	$200	$87	$165	$215	$114	$210	$297
65+	$36	$70	$87	$89	$168	$217	$95	$180	$230	$110	$199	$285

AGE	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$52	$98	$125	$110	$209	$271	$125	$235	$305	$160	$304	$406	$5	$8	$11
45 - 54	$58	$108	$142	$115	$219	$283	$130	$246	$320	$167	$322	$434	$6	$13	$16
55 - 59	$64	$119	$157	$123	$232	$301	$138	$263	$342	$179	$340	$445	$7	$14	$20
60 - 64	$72	$138	$178	$130	$248	$320	$147	$279	$364	$191	$366	$478	$13	$22	$28
65+	$65	$125	$160	$129	$246	$315	$145	$275	$354	$188	$361	$464	$19	$32	$39

Alberta

AGE	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$30	$55	$71	$75	$139	$181	$86	$162	$210	$96	$165	$242
45 - 54	$32	$58	$74	$77	$142	$185	$88	$166	$215	$111	$202	$287
55 - 59	$33	$61	$77	$78	$146	$189	$89	$168	$218	$117	$212	$303
60 - 64	$34	$64	$80	$79	$149	$192	$90	$171	$222	$123	$224	$318
65+	$42	$77	$98	$86	$164	$208	$97	$186	$237	$113	$202	$279

AGE	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$57	$106	$139	$115	$220	$284	$133	$254	$331	$171	$329	$440	$6	$11	$13
45 - 54	$63	$119	$153	$122	$232	$301	$141	$267	$348	$181	$349	$472	$7	$15	$19
55 - 59	$72	$136	$176	$130	$249	$322	$152	$287	$375	$197	$371	$488	$10	$19	$23
60 - 64	$81	$153	$199	$140	$265	$346	$161	$306	$400	$209	$401	$525	$16	$27	$36
65+	$74	$139	$179	$134	$261	$335	$156	$300	$386	$203	$396	$506	$21	$38	$48

Saskatchewan, Manitoba, Northwest Territories, Yukon and Nunavut

AGE	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$25	$47	$59	$57	$106	$137	$65	$123	$159	$87	$144	$230
45 - 54	$26	$48	$61	$58	$109	$139	$66	$126	$162	$97	$176	$249
55 - 59	$27	$51	$65	$59	$110	$145	$68	$128	$166	$102	$184	$265
60 - 64	$28	$54	$67	$60	$112	$147	$69	$130	$168	$111	$196	$279
65+	$33	$65	$82	$67	$127	$163	$75	$145	$183	$123	$215	$296

AGE	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$53	$100	$129	$93	$177	$229	$107	$205	$266	$137	$265	$354	$5	$8	$11
45 - 54	$59	$111	$145	$98	$188	$243	$113	$217	$284	$145	$284	$385	$6	$13	$16
55 - 59	$66	$126	$161	$105	$203	$261	$123	$235	$304	$159	$304	$395	$7	$14	$19
60 - 64	$77	$141	$186	$113	$219	$284	$131	$251	$328	$170	$329	$431	$13	$22	$28
65+	$70	$133	$171	$111	$214	$274	$128	$242	$314	$167	$319	$412	$18	$31	$39

Effective April 1, 2020
Monthly Rates
for Residents of:

Ontario

	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$31	$60	$77	$77	$144	$187	$87	$166	$215	$103	$184	$262
45 - 54	$33	$63	$80	$78	$148	$191	$89	$169	$219	$122	$223	$316
55 - 59	$34	$66	$84	$80	$151	$196	$90	$172	$224	$134	$237	$341
60 - 64	$36	$68	$86	$81	$153	$199	$92	$175	$228	$137	$248	$352
65+	$42	$81	$101	$88	$170	$215	$100	$190	$243	$121	$219	$314

	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$66	$127	$163	$125	$234	$305	$141	$268	$349	$181	$347	$464	$6	$12	$17
45 - 54	$74	$140	$182	$131	$248	$323	$150	$283	$369	$193	$370	$500	$9	$17	$23
55 - 59	$84	$161	$208	$141	$267	$348	$160	$306	$400	$207	$396	$520	$12	$21	$26
60 - 64	$95	$181	$238	$151	$288	$376	$173	$328	$428	$225	$430	$562	$18	$31	$41
65+	$85	$164	$210	$144	$277	$355	$165	$313	$405	$215	$413	$531	$24	$43	$56

Quebec

	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$40	$73	$92	$94	$177	$231	$108	$207	$270	$88	$152	$238
45 - 54	$42	$77	$99	$98	$181	$236	$110	$211	$276	$114	$196	$283
55 - 59	$44	$83	$105	$100	$185	$240	$112	$215	$280	$126	$215	$300
60 - 64	$45	$87	$111	$101	$189	$245	$113	$217	$282	$132	$234	$319
65+	$54	$100	$127	$108	$207	$264	$122	$232	$300	$142	$251	$338

	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$58	$109	$143	$124	$234	$304	$144	$273	$356	$185	$353	$473	$6	$12	$17
45 - 54	$63	$120	$156	$129	$243	$318	$150	$286	$374	$193	$374	$507	$8	$17	$22
55 - 59	$71	$135	$175	$136	$258	$335	$158	$301	$393	$204	$390	$511	$13	$21	$27
60 - 64	$78	$150	$193	$144	$273	$355	$168	$318	$416	$218	$417	$546	$18	$32	$41
65+	$76	$144	$186	$145	$277	$355	$167	$320	$416	$218	$420	$545	$24	$44	$57

New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador

	ZONE Plan 1			ZONE Plan 2			ZONE Plan 3			ZONE Fundamental Plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$30	$57	$74	$64	$120	$156	$71	$134	$174	$89	$153	$252
45 - 54	$32	$61	$77	$66	$122	$159	$72	$136	$176	$106	$194	$274
55 - 59	$33	$65	$83	$67	$125	$163	$74	$141	$182	$114	$212	$298
60 - 64	$37	$69	$87	$69	$128	$166	$76	$142	$185	$124	$228	$322
65+	$42	$81	$102	$75	$144	$184	$83	$158	$203	$117	$201	$299

	ZONE Plan 4			ZONE Plan 5			ZONE Plan 6			ZONE Plan 7			Optional Hospital Accommodation – can be added to any ZONE plan		
AGE	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
18 - 44	$66	$124	$162	$106	$204	$266	$125	$235	$305	$160	$304	$406	$6	$12	$15
45 - 54	$72	$139	$179	$113	$217	$282	$132	$251	$326	$170	$328	$442	$8	$15	$19
55 - 59	$84	$158	$206	$125	$237	$307	$143	$271	$354	$185	$351	$460	$12	$18	$23
60 - 64	$94	$179	$234	$135	$256	$336	$155	$295	$386	$202	$387	$507	$15	$26	$36
65+	$84	$162	$207	$131	$246	$315	$147	$282	$363	$192	$372	$476	$21	$38	$48

Plans provided by

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HA-ZONE-RATES-N.E.01/20

healthassist®
ZONE

Application for **ZONE** Health Coverage
Green Shield Canada (GSC)

All applicants must complete SECTIONS A, B, C and SECTIONS E and F. If you are applying for ZONE plans 4, 5, 6 or 7, please also complete SECTION D.

SECTION A — Contact Information

Last Name:	First Name:	Initial:
Street Address:		Apt. No:
City/Town:	Province:	Postal Code:
Home Tel: ( )	Business Tel: ( )	Cell: ( )

***Email Address** (so GSC can contact you quickly about your application and benefits):

SECTION B — Coverage Information

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

- ☐ **Single coverage** *Applies to applicant only*
- ☐ **Couple coverage** *Applies to applicant and spouse/partner* **OR** *applicant and one dependent child under age 21*
- ☐ **Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

Select one plan option:

- ☐ **ZONE 1**
- ☐ **ZONE 2**
- ☐ **ZONE 3**
- ☐ **ZONE Fundamental**
- ☐ **ZONE 4**
- ☐ **ZONE 5**
- ☐ **ZONE 6**
- ☐ **ZONE 7**

A: Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No

B: If yes, please indicate if coverage was: ☐ Group ☐ Individual

C: When does or did your coverage end? (YYYY/MM/DD):

D: Name of insurance carrier: ....

☐ Add optional Hospital Accommodation

Total Monthly Rate: $

SECTION C — Individuals to be Covered — please complete in full for EACH person

Last Name	First Name	Initial	Gender	Date of Birth (YYYY/MM/DD)	Age
Applicant:			☐ Male ☐ Female		
Spouse/Partner:			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		

Note: If additional space is required, please attach a separate signed and dated sheet.

If you are applying for ZONE plans 1, 2, 3 or the ZONE Fundamental plan, please proceed to complete SECTIONS E and F.
If you are applying for ZONE plans 4, 5, 6 or 7 and/or the optional Hospital Accommodation benefit, please complete SECTIONS D, E and F.

FOR ADVISOR USE ONLY

Advisor Code:	Advisor Name (first and last):	Advisor Email Address:
Office Code:	Office Name:	Advisor Telephone Number:
MGA Code:	MGA Name:	

gsc green shield canada

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 Please complete **SECTION D** if you are applying for ZONE plans 4, 5, 6 or 7 **OR** if you have selected the optional Hospital Accommodation benefit. Otherwise, proceed to **SECTION E**.

SECTION D — Statement of Health and Prescription Drug Information

1 Have you, your spouse/partner and/or any listed dependent children **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of the following conditions? (Check ✔ , "Yes" or "No" for all questions **AND** **circle** the specific medical condition if applicable.)

		Applicant	Spouse / Partner	Dependent(s)
A:	Anxiety, Depression, Insomnia, ADD/ADHD, Eating disorders or any other Emotional, Mood, Behavioral or Mental health disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B:	Alzheimer's disease, Dementia, Parkinson's disease, Seizures/Epilepsy, Loss of consciousness, Multiple Sclerosis, Paralysis or any other Neurological disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C:	Kidney stones, Kidney Disease, Interstitial Cystitis, Benign Prostatic Hyperplasia (BPH) or any other Kidney, Bladder or Prostate disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D:	Liver disorders, including Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E:	Infertility, Ovarian cyst, PCOS, Uterine Fibroids, Irregular menses, Menopause or any other Reproductive or Breast disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
F:	Crohn's disease, Ulcerative Colitis, Irritable bowel syndrome, Ulcer, Hernia, Persistent heartburn/Reflux or any other Gastrointestinal disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
G:	Heart disease, Stroke/TIA (mini-stroke), Heart attack, Irregular heartbeat, Angina, High blood pressure, Elevated cholesterol or any other Circulatory, Heart or Vascular disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
H:	Alcoholism or Drug dependency	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
I:	Skin disorders, including acne	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
J:	HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
K:	Arthritis, Osteoporosis/Osteopenia, Back pain, Joint pain, Muscle pain, Fibromyalgia or any other Joint, Bone, or Muscular disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
L:	Allergies, Asthma, COPD, Chronic Bronchitis, Emphysema, or any other Respiratory or Lung disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
M:	Chronic headaches or Migraines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N:	Basal cell carcinoma, Growths, Polyps, Tumors, Leukemia or any other Cancers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
O:	Cold sores, Herpes or any other Sexually transmitted diseases or infections (STDs or STIs)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
P:	Diabetes/Elevated Glucose, Hypothyroidism, Hyperthyroidism, Adrenal Fatigue or any other Endocrine, Hormonal or Thyroid disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Q:	Glaucoma, Cataracts, Meniere's disease or any other Eye, Ear, or Balance disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
R:	Any other condition, disease, disorder, or injury not listed above – please check (✔) Applicant, Spouse/Partner or Dependent(s) and specify below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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If you answered "Yes" to any condition(s) in SECTION D-1 above, please identify which question [letter(s) A–R] and provide details below:

Question Letter	First Name of Person	Date(s) Diagnosed (YYYY/MM)	Drugs / Treatment	Nature of Illness, Injury or Condition and Results of Treatment

NOTE: If additional space is required, please attach a separate signed and dated sheet.

2	Do you, your spouse/partner and/or any listed dependent children currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? ☐ Yes ☐ No Prescription drugs include oral medications, injectables, creams, drops or serum.

If you answered "Yes" to this question, please provide details below:

Prescription Drug Information

First Name of Person	Name of Drug	Drug Identification Number (DIN)	Strength	Daily Dosage	Length of Time Using This Drug	Number of Refills Per Year	Date of Last Refill (YYYY/MM/DD)

NOTE: If additional space is required, please attach a separate signed and dated sheet.

		Applicant	Spouse / Partner	Dependent(s)
3	Have you, your spouse/partner and/or any listed dependent children been hospitalized in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Do you, your spouse/partner and/or any listed dependent children expect to be hospitalized in the next six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to question 3 or 4, please provide details below:

First Name of Person	Illness/Injury Treated	Date of Illness, Injury or Confinement (YYYY/MM)	Actual or Anticipated Number of Days in Hospital	Details/Outcome of Illness or Injury

NOTE: If additional space is required, please attach a separate signed and dated sheet.

		Applicant	Spouse / Partner	Dependent(s)
5	Have you, your spouse/partner and/or any listed dependent children consulted a physician annually over the last two (2) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Provide the name and telephone number of the physician who holds the majority of your health records. If you do not have a doctor, indicate "None".

Name of Physician/Medical Clinic: Telephone Number: (   )

GSC reserves the right to perform claim audits from time to time to verify the accuracy of health information provided.

 Reminder: BOTH Payment Authorization AND Declaration sections must be signed.

SECTION E — Payment Information (Applications without payment cannot be processed)

Your first payment for one month's premium will be taken when your application is approved. The next payment (for one month's premium) will be taken on or about your coverage start date (your coverage effective date), depending on the day of the week the first of the month falls. This ensures your payments (and benefits!) are secure a month in advance. Subsequent payments are taken on or around the first of every month. You can begin using your Health Assist benefits on your coverage effective date. Questions about payments? Call 1.800.268.6613, ext. 4460.

Choose ONE Method of Payment

☐ **Pre-authorized Credit Card** ☐ Mastercard ☐ Visa ☐ American Express

Name (as it appears on card): Credit Card Number: Expiry:

Address: City/Town: Province: Postal Code:

☐ **Pre-authorized Debit** PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID"

Is this account Personal or Business? ☐ Personal ☐ Business

Is this a joint account? ☐ Yes ☐ No If "Yes", does this joint account require more than one signature? ☐ Yes ☐ No

If two signatures are required, information for both Account Holders must be provided:

1st Account Holder			2nd Account Holder		
Name:			Name:		
Address:			Address (if different from 1st payor):		
City/Town:	Province:	Postal Code:	City/Town:	Province:	Postal Code:
Telephone Number: ( )			Telephone Number: ( )		

Payment Authorization I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.payments.ca. I/We hereby authorize GSC to withdraw payments from the account specified above on or about the first business day of the month as outlined above. Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change. GSC may terminate coverage in the event that a withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur. I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.payments.ca. I/We represent and warrant that the payment information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

X **Signature(s) Required:**

Signature of Account Holder: .... Date (YYYY/MM/DD): ....

2nd Signature (if joint account): .... Date (YYYY/MM/DD): ....

SECTION F — Declarations and Authorizations — ALL APPLICANTS MUST SIGN

NOTE: This authorization must be signed by the applicant and spouse/partner (if applicable). 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, and together with any other forms signed by me/us in connection with this application, form the basis for any coverage approved. I am authorized to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits. I/We understand that 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. If I/we apply for a medically underwritten plan, I/we understand that my/our policy will not cover any injury or medical condition that predates the effective date of coverage. It is my/our obligation to notify GSC of any change in the health of anyone listed in this application due to either injury or illness which occurs after the date of application and prior to the effective date of coverage. 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, or that of my spouse/partner or any listed dependent children, to exchange such information as is needed for the purpose of this application, to administer benefit claims, to provide access to other GSC services, and/or to confirm the accuracy of the information with GSC. I/We acknowledge that all information provided to GSC may be shared with the licensed advisor connected with this application for the purposes identified above, and for policy administration purposes. I/We understand that my/our personal information may also be shared with GSC service providers that require this information to perform their services, as is reasonably necessary, for the purposes identified above. Additional information on GSC's privacy policies and procedures is available online at www.greenshield.ca.
A reproduction of this consent and authorization shall be as valid as the original.

X **Signature(s) Required:**

Signature of Applicant: .... Date (YYYY/MM/DD): ....

Signature of Spouse/Partner: .... Date (YYYY/MM/DD): ....

ADVISOR'S REPORT – For Advisor/Agent Use Only

I confirm that I have disclosed the following information to the applicant: the name of the company or companies I represent; that I receive commissions for the sale of health and dental products and may receive bonuses or other incentives; and any conflicts of interest I may have with respect to this transaction.

Advisor Name (first and last):	Advisor Code:	X Advisor Signature:

Please send applications to GSC, Individual Products Team, 5140 Yonge St., Suite 2100, Toronto, ON M2N 6L7