PARA MED+

Extended Health, Travel and Dental coverage

Extended Health, Travel and Dental coverage

AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

NOTICE : This authorization applies to the insured, his spouse, as well as any dependents who are the subject of the insurance application.

In order to assess insurability, maintain your file and claims assessment, any individual or legal entity holding personal information about you including any health information, medical history or eligibility for claims, are authorized to transmit such information to the insurer, its agents or its reinsurers upon request. This includes physicians or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, personal information agencies, financial advisors, any financial institutions, the owner, our employer or previous employer, the CNESST or other Workmen's Compensation Board, Canada or Quebec Pension Plan, the SAAQ or other Department of Motor Vehicles, the RAMQ or other provincial Health Departments, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Furthermore, the insurer or its agents are authorized to transmit the information to such third parties as well as its reinsurers. For the same purpose and to gather the same type of information, the insurer, its agents or its reinsurers may request an investigative report about you and to use information in their possession in other files.

This consent is also valid for the gathering, use and transmission of personal information concerning your minor children. No modification or alteration of this consent will affect its content nor bind the insurer.

This consent may also be used for a request for additional insurance or a contract modification.

AGREEMENT FOR THE ESTABLISHMENT OF A PERSONAL FILE

The insurer may retain the services of a specialized administrator to manage your insurance file as well as your claims. To ensure the confidentiality of your personal information, the insurer will establish a file in which such personal information will be held, and whose purpose is to allow you to benefit from an insurance coverage and additional financial services the company offers. Only authorized employees of the insurer or specialized administrator will have access to this file.

In the case of an insurance contract including your spouse or dependents, please notify the persons concerned that documents containing personal information will be sent directly to you.

You are entitled to access your file and, if applicable, to rectify any information that you prove to be inaccurate, incomplete, ambiguous, outdated or unjustified.

To do so, a written request must be sent to the Officer in charge of the access to information at the following address:

UV INSURANCE
C.P. 696, DRUMONDVILLE, QUEBEC J2B 6W9
Phone: 819 478-1315
Toll free: 1-800 567-0988
Fax: 819 474-1990

Give this copy to the proposed insured

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APPLICATION

☐ New enrolment ☐ Addition or Modification to existing contract ☐ Reinstatement **Contract No.:**

Name of firm :	Agent information	Code	%
	Name of agent 1 (administrator) :		
	Name of agent 2:		

1. INSURED INFORMATION

Occupation :

First Name : Last Name :

Date of Birth : ____________________________
DD / MM / YYYY

Gender : ☐ M ☐ F

Language preference : ☐French ☐English

Address : ____
P.O. Box No. & Street Apt City Province Postal Code

Telephone : _________________________ _________________________ _________________________
Home Office Cell

E-mail : ____

2. CHOICE OF COVERAGE

☐ Single ☐ Family ☐ Couple ☐ Single parent **Premium:** ☐ **Levelled** ☐ **Attained age**

		Monthly Premium $
Extended Health Insurance* Travel Insurance included in EHC	Plan: ☐ Basic ☐ Basic Ultra **Please complete all sections of this application, except for section 6**	
	Plan: ☐ Select ☐ Deluxe ☐ Optimum **Please complete all sections of this application**	
Drug Plan	Complement: ☐ 1,250 ☐ 2,500	
Home Care Assistance	Option: ☐ $25,000	
Dental insurance	Plan: ☐ Basic ☐ Deluxe	
Other		
	Total monthly premium	
	Total annual premium = (Total monthly premium x 12)	

Does one of the persons to be insured currently have or have had individual health insurance with UV Insurance? ☐ **Yes** ☐ **No**
If yes, please specify the contract and certificate numbers.

Contract: ________________________________ Certificate: ________________________________

Do you currently have an individual or group insurance policy that covers you for dental care? ☐ **Yes** ☐ **No**
If yes, please indicate the contract number and the name of the company.

Contract: ________________________________ Company: ________________________________

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3. SPOUSE AND DEPENDANT CHILD* INFORMATION

Please note that the information of the insured persons must be indicated below.				Date of Birth		
	First Name	Last Name	Gender	Day	Month	Year
Spouse(1)			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			
Dependant Child			☐ M ☐ F			

(1) If common-law spouse, please specify the date cohabitation began (DD/MM/YYYY)_______/______/________.

***Dependent child** means an unmarried child of the insured (whether a natural child, a stepchild or an adopted child), of his or her spouse, or of both of them, who depends on the insured for his or her support and who:

1) Is older than 24 hours and younger than 21 years of age and does not work more than 20 hours a week, unless he or she is a full-time student;
2) Is 21 years of age or older but less than 26 if he or she is a regular full-time day student in a recognized academic institution; or
3) Regardless of age, has a physical or mental disability resulting from an accident or sickness that requires regular medical care. The disability must have begun while the child was considered a dependent as defined previously and be of such nature that the dependent is totally incapable of pursuing a gainful occupation.

****If the dependent child is over 21 years of age and a full-time student in a recognized academic institution please fill out the application for over-age dependency coverage.**

4. BANKING INFORMATION FOR CLAIMS REIMBURSEMENT ONLY

(Please attach a blank cheque marked "**VOID**")

Name of Financial Institution:

Address of Financial Institution:

Insert the numbers found on the bottom of the cheque, as shown in the following example:

Branch number:	Financial Institution Number (Bank):	Account Number:

Underwritten by:
UV Insurance P.O. Box 696, Drummondville, Quebec J2B 6W9 | Tel. 819 478-1315 Toll free 1-800 567-0988 Fax 819 474-1990

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5. PREMIUMS AND METHOD OF PAYMENT

☐ **Monthly Pre-authorized debit $____________** (See Pre-authorised debit section)
Desired withdrawal date : the_______day of each month (**except 29th, 30th and 31st**)

☐ **Annual Pre-authorized debit $____________** (See Pre-authorised debit section)
The initial withdrawal date will be the same as the date of issue of the contract. Afterwards, the withdrawal date will be the same as the renewal date.

☐ **Annual $______________**
Make cheque payable to: « **Odyssey Insurance in Trust** », third party administrator on behalf of the insurer.

PREAUTHORIZED DEBIT (PAD) AGREEMENT

Banking Information

Please attach a blank cheque marked « VOID »

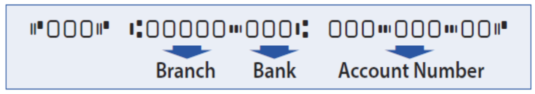
Name of Financial Institution : __________________________________

Address of Financial Institution : _______________
____
____

Name of payer : __________________________________

Address of payer: _________________________________
____
____

Branch Number : _____-_____-_____-_____-_____
Financial Institution Number : _____-_____-_____
Account number : ___________________________



Type of Service	☐ Personal – If debit is from a personal account ☐ Business – If debit is from a corporate account
Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.	1. I authorize the insurer, or his authorized representative, to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. 2. If a preauthorized debit is return due to insufficient funds (NSF) in the account, the insurer or his authorized representative, will withdraw the related $25 fee from that same account, without notice. 3. I agree to the debiting if my account on the regular preauthorized debit (PAD) withdrawal day as indicated on the application or the next business day (subject to change)
Waiver	**I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal***
Cancellation	You may cancel this preauthorized debit agreement at any time, subject to providing the insurer or his authorized representative with 10 days written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca)
Method of Payment	Any cancellation of this preauthorized debit agreement will not affect the agreement between you and the insurer whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca
Exclusive Rights	All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance contract.

*The insurer or its authorized representative will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.

Date & Signature	____________________ Date	____________________________ Account Owner Signature
	____________________ Date	____________________________ 2nd Account Owner Signature (if applicable)

6. HEALTH QUESTIONS - FOR EXTENDED HEALTH PLAN SELECT, DELUXE AND OPTIMUM

Any reference to test results, excludes genetic tests. Genetic test means a test that analyses DNA, RNA, or Chromosomes for purposes such as prediction of disease or vertical transmission risks. Do not provide any information about genetic tests in this application, other questionnaires or forms. However, you must answer all other questions truthfully including information about all other types of medical tests.

A) Pre-underwriting questionnaire

Have you or your spouse or dependent child listed ever received care, been diagnosed or experiences symptoms relating to the following disorders:

- AIDS, AIDS-related complex or HIV infection
- Alzheimer's disease
- amyotrophic lateral sclerosis (ALS disease)
- angina
- cancer (except basal cell carcinoma)
- chronic fatigue
- autism spectrum disorders
- chronic pancreatitis
- chronic renal failure
- cirrhosis of the liver
- cystic fibrosis
- diabetes (type 1)
- heart attack
- hepatitis B or C
- fibromyalgia
- dementia
- multiple sclerosis
- organ transplant (except corneal)
- Parkinson's disease
- rheumatoid arthritis
- stroke
- systemic lupus erythematosus?

Yes ☐ No ☐

If any proposed insured answered YES to the above pre-underwriting questionnaire, he/she is not eligible for this underwritten product.

B) Underwriting questionnaire: (Only complete the following questionnaire for each proposed insured that have answered no to the pre-underwriting questionnaire).

1.

First Name/Last Name	Name of family physician	Date of last consultation, reason, results and treatment	Height	Weight
Proposed insured		Date: Reason: **Results/treatment:**	cm ☐ _____ in ☐ _____	kg ☐ _____ lbs ☐ _____
Spouse		Date: Reason: **Results/treatment:**	cm ☐ _____ in ☐ _____	kg ☐ _____ lbs ☐ _____

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First Name/Last Name	Name of family physician	Date of last consultation, reason, results and treatment	Height	Weight
Dependent child		Date: Reason: **Results / treatment:**	cm ☐____ in ☐_____	kg ☐ _____ lbs☐ _____
Dependent child		Date: Reason: **Results / treatment:**	cm ☐____ in ☐_____	kg ☐ _____ lbs☐ _____
Dependent child		Date: Reason: **Results / treatment:**	cm ☐____ in ☐_____	kg ☐ _____ lbs☐ _____
Dependent child		Date: Reason: **Results / treatment:**	cm ☐____ in ☐_____	kg ☐ _____ lbs☐_____
Dependent child		Date: Reason: **Results / treatment:**	cm ☐____ in ☐_____	kg ☐ ____ lbs☐_____

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2. In the **past five (5) years,** have you or your spouse or dependent child listed ever received care, been diagnosed or experiences symptoms relating to the following disorders:

	YES	NO
a) **Cardiovascular system:** arrhythmia, heart murmur, high blood pressure, high cholesterol, or any other cardiac, circulatory or blood vessels disorder?	☐	☐
b) **Digestive system:** ulcer, ulcerative colitis, Crohn's disease, polyps, disorder of the stomach, pancreas, intestines, liver, or any other gastrointestinal disorder?	☐	☐
c) **Endocrine or blood system:** diabetes, anemia, leukemia, thyroid disorder, gout, or any other endocrine or blood disorder?	☐	☐
d) **Genito-urinary system:** chronic bladder infections, kidney stones, disorder of the kidneys, prostate, uterus, cervix, breast, urinary tract or any other genital or urinary disorder?	☐	☐
e) **Immune system:** Lyme disease, AIDS or AIDS-related complex, or other immune disorder or deficiency?	☐	☐
f) **Musculoskeletal system:** back or neck disorders (including low back pain), muscle, bone or ligament disorders, arthritis, or any bone or joint disorder?	☐	☐
g) **Neurological system:** transient ischemic attack (TIA), chronic headaches, migraines, dizziness, vertigo, seizure, epilepsy, paralysis or any other neurological or brain disorder?	☐	☐
h) **Nervous system:** anxiety, depression, anorexia or any other eating disorder, attention deficit disorder (with or without hyperactivity), or any other mental, nervous or emotional disorder?	☐	☐
i) **Respiratory system:** asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, or any other respiratory or lung disorder?	☐	☐
j) **Other conditions or diseases:** tumor, eye, ear or skin disorder (including acne)?	☐	☐

3. In the **past two (2) years,** have you or your spouse or dependent child listed:

	YES	NO
a) Consulted or been advised to consult or received treatment from any of the following health professionals: physiotherapist, massage therapist, podiatrist, chiropractor, acupuncturist, nutritionist, psychologist, speech therapist, homeopath, or naturopath?	☐	☐
b) Required, used, or been advised to use any of the following equipment, device, or medical accessories: artificial limbs, wheel chair, walker, orthopedic devices or arch supports, oxygen, CPAP machine, ostomy supplies, diabetic supplies or equipment?	☐	☐
c) Been treated for alcohol or drug dependency or been recommended to reduce your alcohol or drug consumption?	☐	☐
d) Been treated or followed for any congenital or physical impairment, deformity, or illness not covered above or been advised that you should be?	☐	☐

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4. Provide details for each YES answer given in questions 2 and3.

Person's Name	Question	Condition or disease/ Diagnosis	Treatment and cost	Date of treatments (dd/mm/yyyy)	Result of treatment/ extent of recovery
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	
			Treatment: Cost:	First treatment: Last treatment: Frequency of treatment:	

5. Have you or your spouse or dependant child listed been advised to undergo a diagnostic test, a test, an exam, be hospitalised or have surgery even if it has not been completed? ☐ **Yes** ☐ **No**

If YES, specify :

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6. Are you or your spouse or dependent child listed aware of any symptoms or health discomfort for which you have not yet consulted a physician, or received a diagnosis? ☐ **Yes** ☐ **No**

If YES, specify:

7. In the past **twelve (12) months**, have you or your spouse or dependant child listed taken any prescribed medication?

☐ **Yes** ☐ **No**

If YES, complete the following table:

Person's name	**Name of prescribed drug**	**Reason for the prescription**	**Dosage**	**Frequency**	**Monthly cost**	**Date started & date stopped**
						Date started Date stopped Ongoing ☐
						Date started Date stopped Ongoing ☐
						Date started Date stopped Ongoing ☐
						Date started Date stopped Ongoing ☐
						Date started Date stopped Ongoing ☐
						Date started Date stopped Ongoing ☐

____

Signature of the proposed insured

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7. DECLARATIONS, AUTHORIZATIONS AND SIGNATURE

On the date of signing of this application, the proposed insured, in his personal capacity as well as in his capacity of authorized representative of any proposed insured, hereby declares the following that concerning himself/herself and each eligible proposed insured:

(a) He/she is currently working or if not, he/she is not disabled or receiving any type of disability benefits.

(b) He/she is not currently hospitalized or waiting to be hospitalized (including day surgery).

(c) He/she has not been diagnosed or received any treatment (including medication) for any type of cancer in the past five (5) years (except for basal cell carcinoma).

(d) He/she has not tested positive on the AIDS virus antibody test or been diagnosed with AIDS (acquired immune deficiency syndrome) or ARC (AIDS – related complex). Initial ☐

- I confirm that each eligible proposed insured holds a valid card from his/her provincial health government plan.
- I attest to having received my dependent's consent (spouse and/or children) in order to enroll in this individual insurance plan in their name. (only applicable if you have requested coverage for your spouse and/or children)
- I confirm that the information and answers that I have provided in this document are true and complete.
- I confirm that the information and answers that I have provided are true and complete and acknowledge that they constitute the basis of my insurance coverage.
- I understand that if any answer is false or incomplete, any insurance coverage granted may be voided.
- I understand that I may be refused for insurance coverage if, in the opinion of the insurer, I am not insurable for the insurance coverage.
- I understand that any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date insurer makes a decision must be reported to the insurer.
- I understand that if I fail to do so, any insurance coverage granted may be voided.
- I authorize any doctor, health professional or institution according to the health and social services legislation, insurance companies, or any other agency, institution or person in possession of information about us or our health to transmit it to the insurer and its reinsurers.
- In the event of a claim, I authorize any police force and any other agency that holds information regarding my claim to communicate such information to the insurer and its reinsurers.
- I have retained a copy of this document.
- I acknowledge having been notified that the financial advisor is to be paid by commission in relation to the transactions described in this insurance application. I have been inform the he is independant of the insurer and is not its representative.
- I authorize the insurer to deposit all my claim reimbursements to the designated bank account.
- I acknowledge receipt of the **Authorization to obtain and release personal information to a third party** and the **Agreement for the establishment of a personal file.**
- This authorization is valid for the purposes of this contract, its modification, or its reinstatement.
- I acknowledge that a reproduction of this authorization shall be as valid as the original.
- I authorize the insurer or Odyssey Insurance (Groupe Financier Odyssée Inc) to use my personal information in order to send me information on other products and services that might interest me. If no, please check (√) the following:

☐ I do not authorize this use.

Signed at ____________________________________ on this_______day of ______________________________20______.
(Province)

______________________________________ ______________________________________

Signature of the proposed insured **Signature of the Agent**

____

Signature of the spouse

Underwritten by:
UV Insurance P.O. Box 696, Drummondville, Quebec J2B 6W9 | Tel. 819 478-1315 Toll free 1-800 567-0988 Fax 819 474-1990