Consulting & Benefits
Working Enterprises Consulting & Benefits Services Ltd.

BROKER #

VALUE BENEFITS PROGRAM APPLICATION FORM

SECTION 1: Applicant Information (PLEASE COMPLETE THIS SECTION FOR APPLICANT ONLY)

WHICH PLAN ARE YOU APPLYING FOR?

- ☐ VALUE PLAN - Guaranteed Issue (pre-existing conditions are covered)
- ☐ VALUE PLUS - Medically Underwritten Individually
- ☐ GOLD VALUE - Medically Underwritten One or More Individuals

MONTHLY COST

FULL NAME (PLEASE PRINT CLEARLY) — SURNAME / FIRST NAME

DATE OF BIRTH — MM/DD/YYYY

GENDER ☐ MALE ☐ FEMALE

MAILING ADDRESS — ADDRESS / CITY / PROVINCE / POSTAL CODE

PHONE NUMBER ( ) — AREA CODE

EMAIL ADDRESS

ORGANIZATION

SECTION 2: Dependent Information (ONLY IF APPLICABLE) - IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET

If listing a dependent between the ages of 21 - 25, please attach proof of full time student enrollment.

NAME	RELATIONSHIP TO APPLICANT	GENDER (M/F)	DATE OF BIRTH (MM/DD/YYYY)

SECTION 3: Medications (PLEASE PRINT CLEARLY)

Please list all medications you, your spouse/partner or any listed dependent children have taken in the last 3 months, including those for which refills are currently authorized or any medications prescribed or expected to be prescribed in the near future. If additional space is required, please attach a separate sheet. **Note: Prescription drugs include oral medications, injectables, creams, drops, or serum.**

PATIENT NAME	MEDICATION	DOSAGE	FREQUENCY	MONTHLY COST	NATURE OF ILLNESS
Example: John	Avandia	50mg 1 tab	2x day	$55.00	Diabetes

How long is medication expected to be taken? (Indicate for each medication) _____

_____

_____

List any symptoms or complaints, and/or medical tests, for which you or your dependents have not yet sought treatment, received results, follow-up or had medications prescribed but not yet filled. _____

_____

_____

SECTION 4: Group Conversion Privilege

Are you converting from a previous Group Plan within 60 days of its termination? ☐ YES ☐ NO

If YES please provide the following information: Carrier Name: _____ Plan Number: _____

Date Coverage Terminated: _____

NOTE THAT COVERAGE TAKES EFFECT THE FIRST OF THE MONTH FOLLOWING APPROVAL

SECTION 5: Underwriting Questionnaire

1. In the last 5 years have you or your dependents been treated for or had any indication of heart attack, heart disease, stroke, cancer, diabetes, mental or nervous disorders, arthritis or any condition that required treatment or required medication that exceeded $500 per year in cost? ☐ YES ☐ NO
2. IF YOU ANSWERED YES AND THIS IS NOT A GROUP CONVERSION, DO YOU WANT EXISTING DRUGS TO BE EXCLUDED ON THE VALUE PLUS OR GOLD VALUE PROGRAM? ☐ YES ☐ NO
3. If you answered NO to question 2 above the program WILL BE ISSUED as a VALUE Plan (Health coverage only) unless you are converting from a previous group plan under Section 4 of this application.

SECTION 6: Agreement and Declaration

1. I declare that I, my spouse/partner and all listed dependents have provincial health care coverage.
2. I agree that the statements contained herein are true and complete, to the best of my knowledge and form the basis for any coverage approved and that Green Shield Canada and the plan administrator reserve the right to validate the answers to the questions in this application.
3. I understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or listed dependents could result in denial of a claim and the cancellation or modification of the coverage.
4. I am authorized to release information concerning my spouse/partner and my dependent child(ren) for the purpose of determining their eligibility for benefits.
5. I hereby authorize any licensed physician, or other medical practitioner, medical or medically related facility, that has any records or knowledge of me or my health, or that of my spouse/partner or any listed dependents, to exchange any such information as is needed to administer benefit claims and/or confirm the accuracy of the information with the plan administrator and/or Green Shield Canada. I may request and receive a copy of any medical information obtained with this authorization. A photographic copy of this authorization shall be as valid as the original.
6. I hereby understand that the coverage applied for shall be effective on the 1st of the month following notification of approval. I understand that it is my obligation to inform the plan administrator of a change in my health or that of my listed dependents due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.
7. I declare that I am able to read and/or speak English or French and acknowledge having read this notice. Notice of disclosure from agent or broker to the applicant: I declare that I am remunerated by commissions from the plan administrator depending upon volume of sales.

Signed at: _____ Date: _____
MM/DD/YYYY

Signature of Applicant: _____

SECTION 7: Pre-Authorized Chequing (PAC) PLEASE ATTACH A VOID CHEQUE

I hereby request/authorize you to debit my account, as shown on the attached void cheque, for each month's premium payable to the current plan administrator chosen by the plan sponsor and/or its successors or assigns. Your treatment of each payment shall be as if it were a cheque drawn on you and signed personally by me. This authorization may be cancelled at any time by me as long as you the plan administrator have received 10 days written notice before my next scheduled withdrawal date. Under this premium payment method, the company(s) shall not be required to give notice of premiums due. The expression "cheque" used in this request includes magnetic or computer paper tape that is or purports to be a direction to credit any amount to the company and debits such amount to the account described.

If a pre-authorized cheque is returned due to non-sufficient funds, the plan administrator is authorized to redeposit the cheque or add the appropriate amount to the next cheque. A $25.00 service fee will be applied by the plan administrator to all NSF cheques. Notification of any change to the account information shall be given to the plan administrator by the payor, no less than 10 days prior to the next scheduled withdrawal date. Premiums will be withdrawn on the 1st of each month.

Name of Bank: _____ Transit#: _____ Institution#: _____ Account #: _____

Master Card/Visa #: _____ Expiry Date: _____ Name on Card: _____

Date: _____ Signature (as it appears on bank records) _____

Date: _____ Signature (if required for joint account) _____

SECTION 8: Agent Information

Agent Signature: _____ Print Name: _____ Number: _____

Dated at: _____ in the Province of _____, this ____ day of _____, 20 _____

WE Consulting & Benefits: #206 - 2248 Elgin Avenue Port Coquitlam, BC V3C 2B2
Toll Free: 1-855-863-9991 | Email: dave@weconsultants.ca