Johnson Personal Health Plan Application Form

for Individual Health and Dental Coverage

For Johnson Inc. Use Only		
Plan Sponsor Name:	**Plan Sponsor ID Number:**	**GSC ID Number:** JAC

Note: Plan administered by Johnson Inc. Claims and risk managed by Green Shield Canada.

PLEASE PRINT AND COMPLETE THIS FORM IN FULL

SECTION A – *Applicant Information*

First Name | Initials | Last Name

Address - Street/Apt.

Gender
☐ Male
☐ Female

City/Town | Province | Postal Code

Date of Birth
Day | Month | Year

Provincial /Territorial Health Insurance Card No.

Daytime Telephone Number
Area Code

Name of Employer / Association

Email Address

SECTION B – *Coverage Information*

1. I declare that I, and my spouse/partner and all listed dependents, have provincial or territorial health care coverage.
2. a) I/We are applying for: ☐ Single coverage ☐ Couple coverage ☐ Family coverage

   b) I/We are selecting: ☐ **Optimum Plan** *(Health, Prescription Drugs and Dental)*

   ☐ **Preferred Plan** *(Health and Prescription Drugs, no Dental)*

   ☐ **Standard Plan** *(Health and Dental, no Prescription Drugs)*
3. a) Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No

   b) If yes, please indicate if coverage was a/an ☐ Group health plan or ☐ Individual health plan

   c) When does/did your coverage end? Day:_____ Month:_____ Year:_____

   d) Name of insurance company: _____

SECTION C – *Spouse/Partner and Dependent Information*

First name	Last name	Provincial or Territorial Health Card Number	Gender M / F	Date of Birth Day / Month / Year	Student Ages 21 – 25 Yes / No	Disabled Yes / No
Spouse/Partner:						
Dependent:						
Dependent:						

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

SECTION D – *Statement of Health and Prescription Drug Information*

Complete SECTION D if you are applying for the Optimum Plan or Preferred Plan. If you are applying for the Standard Plan, proceed to SECTION E.

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

1. Have you, your spouse/partner and/or any listed dependent been hospitalized in the last two (2) years?

Applicant:	☐	Yes	☐	No
Spouse/Partner:	☐	Yes	☐	No
Dependent:	☐	Yes	☐	No

2. Do you, your spouse/partner and/or any listed dependent expect to be hospitalized in the next six (6) months?

Applicant:	☐	Yes	☐	No
Spouse/Partner:	☐	Yes	☐	No
Dependent:	☐	Yes	☐	No

If you answered "yes" to Questions 1 or 2, please provide details below:

First name of person	Date of illness, injury or confinement Month / Year	Actual or anticipated number of days in hospital	Details / outcome of injury or illness

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

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

Medical Condition	Applicant	Spouse/Partner *(if applicable)*	Dependent *(if applicable)*
a) Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures/Paralysis	Y / N	Y / N	Y / N
b) Stomach, Intestinal, Kidney, Bladder or Liver Disorder (including Hepatitis)	Y / N	Y / N	Y / N
c) Infertility, Reproductive Disorder or Menopause	Y / N	Y / N	Y / N
d) Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia or persistent Heartburn	Y / N	Y / N	Y / N
e) Circulatory, Heart or Vascular Disease, High Blood Pressure, Angina, Stroke, T.I.A.	Y / N	Y / N	Y / N
f) Elevated Cholesterol	Y / N	Y / N	Y / N
g) Alcoholism or Drug Dependency	Y / N	Y / N	Y / N
h) Skin Disorder (including Acne, Rosacea, and Eczema)	Y / N	Y / N	Y / N
i) AIDS, ARC (AIDS Related Complex), HIV or other Immunological Disorder	Y / N	Y / N	Y / N
j) Arthritis/Rheumatism, Osteoporosis, Bone Density Loss, Back, Joint or Muscle Pain	Y / N	Y / N	Y / N
k) Lung condition/Respiratory conditions including COPD, Asthma or Allergies	Y / N	Y / N	Y / N
l) Headaches/Migraines	Y / N	Y / N	Y / N
m) Cancer, Tumor or Leukemia	Y / N	Y / N	Y / N
n) Sexually Transmitted Diseases (STD or STI) or Recurring Infections (including Cold Sores or Herpes)	Y / N	Y / N	Y / N
o) Diabetes, Endocrine, Hormonal or Thyroid Disorder	Y / N	Y / N	Y / N
p) ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)	Y / N	Y / N	Y / N
q) Glaucoma	Y / N	Y / N	Y / N
r) Other Condition/Disease/Disorder/Injury not listed above. If yes, please specify: _____	Y / N	Y / N	Y / N

Note: A modified version of the selected benefit plan may be offered based on the health information provided.

If you answered "yes" to any of the conditions in Question 3, please provide details below:

Question letter	First name of person	Nature of illness, injury or condition	Date of first visit / treatment Month / Year	Date of last visit / treatment Month / Year	Drugs / treatment	Result of last consult/ current status

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

4. Do you, your spouse/partner and/or any listed dependent currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? Prescription drugs include oral medication, injectables, creams, drops or serum.

Applicant: ☐ Yes ☐ No

Spouse/Partner: ☐ Yes ☐ No

Dependent: ☐ Yes ☐ No

If "yes", please provide details below:

First name of person	Name of drug/medication/ serum/cream	Strength and daily dose of the drug/medication/ serum/cream	Daily dosage of the drug/medication/ serum/cream	Length of time on this drug/medication/ serum/cream	Number of refills per year

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

5. Have you, your spouse/partner and/or any listed dependent consulted a physician annually over the last two (2) years?

Applicant: ☐ Yes ☐ No

Spouse/Partner: ☐ Yes ☐ No

Dependent: ☐ 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: ( ) _____

Johnson Inc.'s Commitment to Privacy

Your personal information is collected for the purpose of providing you with health and dental benefits, claims analysis and payments. For more information on Johnson Inc.'s privacy policies and procedures, visit johnson.ca.

SECTION E – *Declarations and Authorizations (please read and sign below)*

Completed applications are to be mailed to Johnson Inc. along with a blank cheque marked "VOID". Please ensure all sections are completed or the application will be returned to you.

1. I (the applicant) hereby apply for benefit coverage with Green Shield Canada.
2. I am authorized to release information concerning my spouse/partner and/or dependent, for the purposes of determining their eligibility for benefits.
3. By signing this application form, I/we declare the statements contained in this application, including but not limited to the Statement of Health, are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any Contract issued hereunder.
4. I/We understand any health information must be accurate as at the date the application is signed. Any misrepresentation, including misstatement shall render the benefit coverage voidable at the discretion of Green Shield Canada.
5. I/We understand that it is my/our obligation to notify Johnson Inc. of a change in the health of anyone listed in Section C due to either injury or illness which occurs after the date of application and prior to the effective date of coverage.
6. I/We understand there are exclusions and limitations on the coverage applied for.
7. I/We understand based on the health information provided, coverage may be declined or modified to exclude certain medical conditions.
8. 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 dependents, to exchange such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with Green Shield Canada.
9. By applying for coverage I/we understand my/our information may be used to confirm sponsored group membership and eligibility under this Plan.
10. I/We understand coverage will take effect on the first of the month following the receipt of my/our properly completed application (including the Statement of Health) and approval by Green Shield Canada.
11. I/We hereby authorize Johnson Inc. to withdraw premium payments from my/our account thirty (30) days in advance of the due date, on or about the 5th day of each month.
12. I/We further authorize my/our premium for this benefit coverage, including any adjustments, arrears and renewals to be deducted in monthly amounts from my/our chequing account.
13. Should there be any change in either the amount or premium due date, Johnson Inc. will give the applicant written notice of at least thirty (30) days in advance.
14. I/We understand my/our coverage will be automatically terminated should Johnson Inc., the Plan Administrator, receive two or more Non-Sufficient Funds (NSF) notices on my/our account.
15. I/We understand coverage will automatically be renewed under the policy terms and conditions then in effect, unless I/we provide written notice of termination to the Plan Administrator within 60 days from the first premium deduction for the Policy Year.
16. I/We acknowledge that my/our Contract will contain a privacy statement outlining how my/our personal and other information may be collected, used and disclosed in connection with my/our coverage, claims thereunder and other stated purposes among Johnson Inc., Green Shield Canada, my/our sponsor group and any other applicable parties. For privacy information, please refer to johnson.ca or greenshield.ca.
17. A reproduction of this declaration and authorization shall be as valid as the original.

PAYMENT AUTHORIZATION: I authorize monthly deductions from my bank/trust/credit union account. Due to application processing time, and the effective date of coverage, the initial deduction may cover up to 3 months of premium. If more than one signature is required on cheques issued from a joint account, all depositors must sign below.

☐ **I/We have ATTACHED A BLANK PERSONAL CHEQUE FOR MY/OUR ACCOUNT AND MARKED IT "VOID".**
Subject to Green Shield Canada's approval, I/we understand coverage will begin on the 1st of the month following the approval date of my/our completed application.

_____
Signature of Applicant Date (dd/mm/yy)

_____
Signature of Spouse/Partner Date (dd/mm/yy)
(If applying for coverage)

_____
Signature of Joint Account Depositor Date (dd/mm/yy)
(2nd Signature if Joint Account)

For more information contact Johnson Inc. at:

Telephone:	905.764.4959	1595 16th Avenue
Toll-free:	1.800.461.4155	Suite 700
Fax number:	905.764.4163	Richmond Hill, ON
Website:	johnson.ca/personalhealth	L4B 3S5