

**APPLICANT INFORMATION**

**Name** First Name ..... Last Name ..... Middle Initial(s) .....

**Mailing Address** .....

**City** ..... **Province** ..... **Postal Code** .....

**Phone** Day ..... Evening ..... **Email** .....

**Date of Birth** (MM/DD/YY) ..... **Gender**  Male  Female **Provincial Health Plan Coverage?**  Yes  No

**Smoking Status**  Non-smoker  Smoker *If you are not applying for MAI Premium which contains Critical Illness Insurance, you do not have to answer Smoking Status. Non-Smoker rates apply to MAI Premium applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the last 12 months.*

**Would you like online access to view claims, address information, etc.?**  Yes  No

**PLAN INFORMATION**

**Medical Access Insurance (MAI): Coverage Type**  Single  Couple  Family

**OPTIONAL (MAI Premium) Critical Illness Insurance: Amount of Coverage** \$ ..... (Units of \$25,000, maximum \$150,000)

**SPOUSE INFORMATION (Complete if applicable)**

Please complete this section if you are applying for Couple or Family MAI coverage. CI Amount is optional for Spouse Coverage.

First Name	Last Name	Date of Birth (MM/DD/YY)	Gender (M/F)	Smoking Status (Refer to definition above.)	OPTIONAL: CI Amount (units 25,000; maximum 150,000)	Provincial Health Plan Coverage?
				<input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker		<input type="checkbox"/> Yes <input type="checkbox"/> No

**ADDITIONAL INDIVIDUALS TO BE COVERED (Complete if applicable)**

Please complete this section if you are applying for Family MAI coverage. If you require more space, please attach a separate sheet.

First Name	Last Name	Date of Birth (MM/DD/YY)	Gender (M/F)	Relationship to Applicant	Smoking Status (Refer to definition above.)	Provincial Health Plan Coverage?
					<input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If your Dependent Child is age 19 or over, please complete the following information to confirm their eligibility:**

Norfolk Mobility Benefits Inc. requires annual confirmation of eligibility for all over-age dependents insured. To ensure accurate claims payments, a Request for Coverage Dependent Coverage Form must be completed upon enrolment or as deemed necessary. If applicable, contact Administrative Services at 1-866-416-2259.

First Name as Recorded Above	Full-time Student?	Name & Address of Accredited School, College or University ATTACH PROOF OF ENROLMENT TO THIS FORM
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PREMIUM PAYMENT OPTIONS** Note: All premiums are subject to Provincial Sales Tax, where applicable.

**MONTHLY payment options:**

Credit Card  PAD (Pre-Authorized Debit, complete section on reverse)

**ANNUAL payment options:**

Credit Card  Cheque  Wire Transfer

**AUTHORIZATION:** I authorize Norfolk Mobility Benefits Inc. ("NMB") to debit my account as per the Method of Payment chosen above. Payments will be withdrawn on or around the 1st day of each month for monthly insurance premiums due. I understand this amount may change at a future date as specified in the Policy. NMB will, to the best of its ability, advise me in writing of the revised amount in advance of its effective date. The pre-authorized payment plan may be discontinued by me or NMB upon 30 days written notice. **DISHONOURD TRANSACTIONS:** NMB will charge a \$35.00 fee for each dishonoured transaction (and charge this amount using the Method of Payment above). Privileges will be canceled if there are 2 dishonoured payments in the same policy year and full premium payment of balance of policy year will be required within 30 days.

**CREDIT CARD:** Complete the following

   **Card Number** ..... **Expiry Date** (MM/YY) .....

**Cardholder Name:** ..... **Signature:** ..... **Date** (MM/DD/YY) .....

**CHEQUE:** Make cheque payable to **NORFOLK MOBILITY BENEFITS TRUST**. Attach a cheque for the first month's premium. You will be billed for the balance once approved.

**WIRE TRANSFER:** Banking transfer details will be provided to you upon receipt of this application form.

**Continued on reverse.** ➔

**PAD (Pre-Authorized Debit) Agreement: Complete only if premium payment is made by Pre-Authorized Debit**

Attach your VOID cheque **OR** complete the following section:

<b>Account Holder Name(s)</b> .....			
Address .....	City .....	Province .....	Postal Code .....
<b>Financial Institution Name</b> .....		<b>Withdrawal Arrangement:</b> <input type="checkbox"/> Fixed <input checked="" type="checkbox"/> Variable	
Address .....	City .....	Province .....	Postal Code .....
<b>Financial Institution Number</b> .....	<b>Transit Number</b> .....	<b>Account Number</b> .....	

**RECOURSE:** 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](http://www.cdnpay.ca).

**PAD AUTHORIZATION:** I/We, as the Account Holder(s), authorize Norfolk Mobility Benefits Inc. ("NMB") and the Financial Institution named above or as indicated on the attached VOID cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax and service charges for insurance under this Policy. The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify NMB in writing if there is any change to the banking information set out above. I/We waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/We agree that NMB will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales tax, service charges, or the increase to the PAD amount is a result of my/our request. I/We may cancel this PAD agreement at any time, subject to providing 30 days notice to NMB at the address on the bottom of this form. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD agreement at my/our Financial Institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca). I/We understand that cancellation of this PAD agreement will not have any effect on the insurance provided on this Policy provided that payment is received when due and is made in accordance with the terms of this Policy. This PAD agreement only applies to the method of payment.

**Signature** of Account Holder(s) ..... **Date Signed (MM/DD/YY)** .....

**PRE-EXISTING CONDITION LIMITATIONS**

**MEDICAL ACCESS INSURANCE: Pre-existing Condition means:** 1) A condition for which an Insured Person is given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation prior to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage; or 2) A condition which produced symptoms prior to the Insured Person's effective date of coverage or prior to the effective date of any benefit that is added to existing coverage. These symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests: a) The symptoms would allow one learned in medicine to make a diagnosis of the disorder; or b) The symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment. This includes, but is not limited to any condition for which the Insured Person is already on a Surgical/Procedural Waiting List in Canada. **Pre-existing Condition Limitation:** Benefits for Medical Access Insurance are limited for any Pre-Existing Condition that existed during the 24 months prior to the Insured Person's effective date of coverage. Medical Access Insurance coverage is not provided for any Pre-Existing Condition until after the Insured Person has been continuously insured for 24 months under this policy. This limitation does not apply to a newborn who is insured on the date of birth.

**CRITICAL ILLNESS INSURANCE (IF APPLICABLE): Pre-existing Condition means:** Any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by an Insured Person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of an Insured Person's coverage. **Pre-existing Condition Limitation:** No benefits will be paid if a Covered Critical Illness Condition results directly or indirectly from a Pre-Existing Condition. This limitation applies for the 24 months following the effective date of an Insured Person's coverage.

**AUTHORIZATION**

I hereby authorize Norfolk Mobility Benefits Inc. ("NMB") or its representative(s) to release all medical information including but not limited to all diagnostic and treatment reports, test results and treatment recommendations to my family physician and/or attending Canadian physician(s). I also authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsurance company, government health insurance plan or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named minor children and other non-medical information of me or my named minor children, to give to NMB or its legal representative any and all such information. Any information obtained will not be released by NMB to any person or organization except to insuring or reinsuring companies or other persons or organizations performing business or legal services in connection with my enrolment for the insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that if I decide to add a newborn, foster, step or adopted child for immediate coverage under Medical Access Insurance and such enrolment is not made within thirty-one (31) days from the date of birth or adoption, or within thirty one (31) days from the date I become legally responsible for a step or foster child, I will be required to submit an application (including evidence of insurability) satisfactory to NMB before the insurance is effective. In this case, my dependent Child's insurance is not effective until the date NMB specifies. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this signed authorization shall be valid as long as any claim under the Policy is outstanding.

**PRIVACY AND CONFIDENTIALITY:** Norfolk Mobility Benefits ("NMB") recognizes and respects every individual's right to privacy. When you apply for coverage or submit a claim, we establish a confidential file of personal information. We use the information to administer the individual benefit plan under which you are covered. This includes many tasks, such as: determining your eligibility for coverage, enrolling you for coverage, assessing your claims and providing you with payment, managing your claims, verifying and auditing eligibility and claims, Underwriting activities, such as determining the cost of the plan, analyzing the design options of the plan, and preparing regulatory reports, such as tax slips. We limit access to information in your file to NMB staff or persons authorized by NMB who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Norfolk Mobility Benefits Inc., your health care provider or other insurance and reinsurance companies may also exchange information when the information is needed to administer your Medical Access Insurance plan.

**I confirm that:**

- i) I have read and understand the **Pre-Existing Condition Limitations** contained in this application.
- ii) I understand that my Medical Access Insurance Premium coverage is conditional upon acceptance of my Application by NMB and will become effective in accordance with the Policy.
- iii) I have read the above notice on **Privacy and Confidentiality** and consent to the collection, use and disclosure of my personal information (including personal information about my dependent(s)) required for enrolment and ongoing administration of the plan.
- iv) **MAI Premium Applicants:** If I have applied for Critical Illness Insurance Non-Smoker rates, I confirm that I have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc.) within the last 12 months.

Applicant Signature ( <b>must always sign</b> ) .....	Applicant Name (Print) .....	Date Signed (MM/DD/YY) .....
Spouse's Signature (when applying) .....	Spouse's Name (Print) .....	Date Signed (MM/DD/YY) .....
Dependent's Signature (if 19 or over) .....	Dependent's Name (Print) .....	Date Signed (MM/DD/YY) .....
Dependent's Signature (if 19 or over) .....	Dependent's Name (Print) .....	Date Signed (MM/DD/YY) .....

**FORM SUBMISSION INSTRUCTIONS:** Submit this form to your Medical Access Insurance Broker. If your Broker is not available, in order to expedite this application, fax a copy to 403-451-1551 or e-mail a scanned copy to [admin@acurehealth.com](mailto:admin@acurehealth.com) to check for completion. When confirmed that all information is complete, the original form must be mailed to: Medical Access Insurance, Attn: Application Processing, Box 61164, Kensington RPO, Calgary, AB T2N 4S6.