



Medical Application



The completion of this Medical Application does not guarantee insurance coverage.
If space is insufficient for any question, print the answer on additional paper, sign, date and attach the paper to this form.

1. APPLICANT INFORMATION	Last Name:		First Name:		Middle Initial:
	Street Address:			Unit #:	PO Box:
	City:		Province:	Postal Code:	
	Home Telephone:		Business Telephone:		
	Date of Birth: YYYY MM DD	Height: ____ Feet ____ Inches	Weight: ____ lbs	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Coverage Applied For: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family				

2. DEPENDENT INFORMATION	Please complete the following for your Spouse and / or Dependent Children to be covered.						
	Last Name	First Name	Date of Birth	Relationship to Applicant	Height (Feet & Inches)	Weight (lbs)	Gender M / F
			YYYY MM DD				
			YYYY MM DD				
			YYYY MM DD				
			YYYY MM DD				

3. FAMILY PHYSICIAN	Please complete the following physician information.			
	Name	Address	Telephone	Date of Last Visit
				YYYY MM DD
	Any future visits scheduled with any medical professional for you or your Dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", what type of practitioner is to be seen? _____				
Reason for the visit? _____			Expected date of future visit? YYYY MM DD	

4. HOSPITALIZATION / SURGERY	Have you or any of your Dependents been hospitalized or had any surgery in the past five (5) years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the following.			
	Name of Person	Medical Condition	Surgery or Treatment	Date of Hospitalization or Surgery
				YYYY MM DD
				YYYY MM DD
Have you or your Dependents been advised to have any test, investigation or surgery which has no yet been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please provide details: _____				

5. MEDICATIONS	Are you or any of your Dependents currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the following (include home oxygen, if prescribed).			
	Name of Person	Medical Condition	Medication	DIN Number



Applicant Name: _____ Telephone: _____

Have you or any of your dependents ever been diagnosed with; received medical treatment for; or consulted with a physician for any of the following? Please place a checkmark in the appropriate box.

6. MEDICAL CONDITIONS	Condition	No	Yes	Condition	No	Yes
	Heart Chest Pain, Angina, Heart Attack, Arrhythmia, Murmur, Congestive Heart Failure, Atrial fibrillation, Dizziness, Fainting				High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A (mini-stroke), Stroke, Aneurysm or Circulatory disorder	
Huntington's Chorea, Amyotrophic Lateral Sclerosis or Motor Neuron Disease				Digestive System Disorder or Liver Disease or Disorder Including Hepatitis, Kidney disorder?		
Diabetes, Diverticulitis, Colitis or Crohn's				Skin Disorder (including Acne)		
Immune Disorders including testing for Immune Deficiency Syndrome (AIDS) or Human Immune Syndrome (HIV)				Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD or Emphysema		
Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic fatigue or Fibromyalgia				Nervous, Mental or Emotional Disorders, Alzheimer, Parkinson's, Memory Loss or Seizure Disorder?		
Cancer, Tumor or Growth (except Basal Cell Carcinomat)				Auto-Immune Disorders-Systemic Lupus Erythematosus (S.L.E) or Scleroderma		
Infertility or Reproductive Disorder, Menopause or Prostate Disorder				Alcoholism or Drug Abuse/Dependency		
Chronic Headaches, Migraines or recurrent infections				Other Condition/Disease/Disorder or Injury		

If you answered "Yes" to any of the conditions above, please provide the details below.

Name of Person	Condition	Date Diagnosed or Treated
		YYYY MM DD
		YYYY MM DD
		YYYY MM DD
		YYYY MM DD

hsacomplete™ Does Not Cover Pre-Existing Conditions

I declare that I am currently in good health and that the information provided is complete and true to the best of my knowledge. I understand that the Application Form is part of the Health Insurance Agreement provided through Echelon General Insurance Company (EGIC). **I acknowledge that if at the time of claim it is discovered that any question in this Medical Application is not answered truthfully, accurately and completely, it will result in the non-payment of any claim and/or my coverage will be null and void.**

Please Note: All costs incurred to validate a condition(s) questioned as being pre-existing in nature by Benecaid, including doctors notes and fees, will be the responsibility of the insured and will not be paid or reimbursed by Benecaid or EGIC.

A Pre-Existing Condition is any Injury, Disease, Sickness, Pregnancy or Mental Disorder for which You did or an ordinarily prudent person would have done any of the following prior to the date on which You became insured under this policy:
a) visited or consulted a physician, hospital or medical facility or b) took clinical tests or received treatment. This includes (but is not limited to) taking pills, injections or other medication to treat any condition.

Your Privacy is Protected: The insurance you are applying for is underwritten by EGIC and administered by Benecaid Health Benefit Solutions Inc. (Benecaid). We respect your privacy and are committed to protecting it. We may use agents, brokers and service providers to collect, use, store and/or process personal information and personal health information on our behalf, and such information may be transferred to these entities to assess underwriting risk and claims experience, underwrite and administer the insurance, investigate and settle claims and detect and prevent fraud for any insurance policy issued to you. Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details regarding how your privacy is protected can be obtained by asking Benecaid for a copy of EGIC's Privacy Policy.

Signature of Applicant: _____ Date: _____ YYYY MM DD

Signature of Spouse: _____ Date: _____ YYYY MM DD
(if coverage required)

Signature of Dependent Child(ren): _____ Date: _____ YYYY MM DD
(if coverage required and age 18 or older)

8. SUBMIT TO

**Echelon General Insurance Company
c/o Benecaid Health Benefit Solutions Inc.
Attention: Data Management Department
P.O. Box 40
Toronto, ON M9C 4V2**

Local Phone: 416-626-8786 • Toll-Free Phone: 877-797-7448 • Local Fax: 416-622-5312 • Toll-Free Fax: 877-797-7449