The Association Health and Dental Plan

Base Plan Outline

Benefits	Coverage Maximums
Dental Services - paid at a percentage of the current Dental Association Fee Schedule or the reasonable and customary charge in your province of residence. • Reimbursement on examinations, cleanings, fillings, scaling, polishing, diagnostic and other basic dental services, including endodontics, periodontics and denture services • Anniversary year maximums • Recall visits	• 70% co-payment • $245 per year • 9 months
Prescription Drugs • Drug Coverage † • Shared Dispensing Fee • Reimbursement per anniversary year.	• Generic coverage* • $6.50 maximum • 70% on first $350
Vision Care- covers the cost towards prescription lenses and frames and/or contact lenses. This benefit does not include industrial safety glasses.	• $100 per 2 benefit years plus $30 for Optometrist visits.
Accidental Death and Dismemberment – payment for a loss directly resulting from accidental bodily injury including loss of life where the loss occurs within a year of the date of the accident.	• $10,000 per adult • 4,000 per child or senior over 65
Best Doctors® Solutions Services – offers evaluation of medical records upon diagnosis of serious illness or injury.	• Covered
Survivor Benefit – provides continuous coverage for 1 year, following the death of an adult Insured.	• Available 1 year after policy effective date
Extended Health Care: Lifetime maximum	• $50,000
Registered Specialists and Therapists – includes visits to Acupuncturists, Chiropractors, Osteopaths, Podiatrists, Naturopaths, Chiropodists, Registered Massage Therapists, Physiotherapists, Psychologists and Speech Therapists. **Registered Specialists and Therapists **** • Maximum claims paid • Per visit maximum • Chiropractic x-rays **Psychologist** ▪ Maximum per first visit ▪ Maximum per subsequent visits ▪ Maximum visits per year **Speech Therapist** ▪ Maximum per first visit ▪ Maximum per subsequent visits ▪ Maximum visits per year	• $300 per specialist/therapist • $20 • $35 per year • $80 • $65 • 10 • $65 • $45 • 10
Homecare and Nursing, Prosthetic Appliances and Durable Medical Equipment – covers the service of registered health professionals including Registered Nurse, Registered Nursing Assistant or healthcare aid; includes surgical bandages and dressings and the purchase or rental of medically necessary equipment such as crutches, non-electric wheel-chairs and hospital beds, oxygen and other equipment recommended by your physician and approved by Manulife Financial. Also includes prosthetic appliances such as artificial limbs, eyes, splints, casts and breast prostheses following mastectomies. Payment will be coordinated where benefits are available through the Assistive Devices Program.	For each of Homecare & Nursing, Prosthetic Appliances and Durable Medical Equipment: Year 1: $1,000 Year 2: $1,300 Year 3: $1,500 Year 4: $2,000 Year 5: $2,500 Custom-made Orthotics: $225 per year as part of Durable Medical Equipment
Lifeline® Response Service – Provides 24-hour monitoring service for people coping with medical problems at home.	• 3 months per lifetime
Hearing Aids – covers the cost to purchase and/or repair up to the allowed amount	• $300 per 4 year period.
Ambulance Services – covers trips to hospitals in a licensed ground ambulance. Covers charges up to the amount between what your provincial health plan covers and what is reasonable and customary. Air ambulance is payable only after provincial plan maximum is reached, if applicable.	• Unlimited ground transport • $4,000 maximum air ambulance
Accidental Dental – covers dental treatment required as a result of an accidental blow to the head or mouth. Treatment must be sought within the 90 day period following the accident.	• $2,000 per year

Monthly Rates (per person)	
Age Group	**Rate**
INDIVIDUAL	
21-44	$45.50
45-54	$56.00
55-59	$58.90
60-64	$61.90
65-69	$69.40
70-79	$73.30
80-89	$76.00
90+	$98.60
COUPLES	
21-44	$38.40
45-54	$48.10
55-59	$50.50
60-64	$53.50
65-69	$60.20
70-79	$64.10
80-89	$66.40
90+	$88.10
1-2 CHILDREN	
0-4	$18.00
5-20	$22.30
3+ CHILDREN	
0-4	$16.20
5-20	$20.20

Premiums are based on individual age at the time of application. Premiums will increase as an individual's age increases in accordance with published age groups.

All references to "year" refer to anniversary year. When it relates to Hearing Aids and Vision benefits, year refers to benefit year. **Anniversary Year** refers to each successive 12-month period following the effective date of the policy. **Benefit Year** refers to each successive 12-month period following the date a claim for a specific benefit is first incurred under the policy.

* Generic drug- A generally less expensive alternative to an interchangeable brand-name drug product. Please Note: not all drugs have a generic equivalent. If a non-generic drug brand exists, payment of the brand-name price will be made at the co-payment level of your plan.

† Birth Control medication and fertility drugs are not covered under this plan.

** Benefits are only payable after yearly maximums allowed under your provincial health insurance plan have been reached, if applicable. Benefits are payable up to Reasonable and Customary charges.

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Benefits underwritten by The Manufacturers Life Insurance Company.

Manulife Financial

Part D • Billing Options

Initial Payment: I hereby authorize Manulife Financial to debit the initial 2 months premium, $______________, from my:

☐ Financial Institution Account ☐ Credit Card Account

Subsequent Payments: Will be made by:

☐ Pre-Authorized Payment Plan (PAP) From My Financial Institution Account (Please also complete PART E below)

☐ Credit Card (Please also complete PART E below): ☐ Visa ☐ MasterCard ☐ Amex Account # ______________________________ Expiry Date ________ (MM / YYYY)

Cardholder ______________________________ (if other than Applicant or Co-Applicant) Signature of Cardholder ______________________________

PAP/Credit Card Billing Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

☐ **Direct Billing:** Direct Billing Frequency: ☐ Semi-annually ☐ Annually

Important: For verification purposes we require a VOID cheque if payment is being withdrawn from your financial institution account.

Manulife Financial may terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25 NSF fee will be charged for all NSF transactions.

Part E • Financial Institution • For Pre-Authorized Payment Plan

Name of account holder(s) if different from Applicant ______________________________

Financial Institution ______________________________

Address ______________________________ City/Town ______________________________

Type of Account: ☐ Personal Chequing ☐ Chequing/Savings ☐ Savings ☐ Current ☐ Direct Deposit Account ☐ Other ______________

Joint Accounts: Is this a joint account requiring only one signature? ☐ Yes ☐ No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-Chequing Accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account. This authorization shall remain in effect unless 30 days written notice is given to Manulife Financial requesting cancellation by the account holder.

For Pre-Authorized Payment and Credit Card billing options: I/We hereby authorize Manulife Financial to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This authorization may be terminated by either Manulife Financial or by me/us through written notice.

______________________________ ______________________________

Signature of account holder Second signature if joint account

If you require more space to complete any part of this application, please attach a separate sheet.

Applicant's Declaration • All Applicants Must Complete This Section

This plan is underwritten by The Manufacturers Life Insurance Company.

☐ Check here if you do not wish to receive further information and material on Manulife Financial's products.

I/We hereby acknowledge that the statements contained herein are true and complete and together with any other forms signed by me/us in connection with this application form the basis for any policy issued hereunder. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, any insurance company, agent, broker, market intermediary, plan sponsor or third party administrator (where applicable), any government agency, investigative or security agency or any other organization or person that has any records or knowledge of me/us or my/our health, or the health of any member of my/our family to be insured under this plan, to provide any such information to Manulife Financial or its reinsurers for the purpose of this application, any policy issued hereunder and any subsequent claim. I/We further authorize Manulife Financial to consult this application and its existing files for this purpose. I/We understand and agree that any injury that occurred or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by my/our policy and that a failure to disclose such information could result in denial of a claim and/or the cancellation or modification of my/our policy. Manulife Financial reserves the right to recover any claims paid due to any failure to disclose any injury or medical condition that existed on or before the date of this application. I/We acknowledge receipt of and agree with the Notice on Privacy and Confidentiality and the Notice on Information Provided to the AIR MILES® Reward Program. I/We understand and agree that coverage shall not become effective until the first of the month following final approval. A photocopy of this signed authorization shall be as valid as the original.

______________________________ ______________________________ Dated ______________

Signature of Applicant Signature of Co-Applicant (DD/MM/YYYY)

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Base Health Plan Application

***All applicants must complete parts A, B, C and D**
***All applicants must complete and sign Applicant's Declaration on page 2.**

AIR MILES # | 8 | | | | | | | | | | |

For Manulife Financial Use Only.
Keyed ______
Approval ______

Agent ID	Logo ID
MB1009	

Part A • General Information

Applicant's Last Name ______ First Name ______ Initial ______ Government Health Card Number | | | | | | | | | | | | |

Apt. Number ______ Street Number and Name ______ Home Telephone ( ) ______

City or Town ______ Province ______ Postal Code ______ Occupation ______

Marital Status: ❑ Single ❑ Married ❑ Other ______

Applicant's Office Telephone ( ) ______ Co-Applicant's Office Telephone ( ) ______

Applicant's Fax ( ) ______ Co-Applicant's Fax ( ) ______

Applicant's Email ______ Co-Applicant's Email ______

If additional information is required during regular business hours, how may we contact you? ❑ Home ❑ Office ❑ Email

Are you now covered or did you have previous health insurance coverage with Manulife Financial or any other insurance company? ❑ Yes ❑ No

If "Yes", please indicate:

Plan Number ______ ID Number ______ Insurance Company ______ Date Benefits ended ______ (DD / MM / YYYY)

Plan Number ______ ID Number ______ Insurance Company ______ Date Benefits ended ______ (DD / MM / YYYY)

Is this application intended to replace your current coverage? ❑ Yes ❑ No

Beneficiary designation for payment of Accidental Death & Dismemberment benefit (in the case of death, if no beneficiary designation is made, benefits will be payable to the estate):

Name ______ Relationship to Applicant ______

Signature of Applicant ______ Dated ______ (DD / MM / YYYY)

If you designate a beneficiary under the age of 18, benefits will be paid into court, unless a trustee is appointed.

Name of Trustee ______ Relationship to Applicant ______

Signature of Applicant ______ Dated ______ (DD / MM / YYYY)

Part B • Plan Choice

I / We are applying for: ❑ Base Health & Dental Plan

Part C • Individuals to be Covered

FIRST NAME	LAST NAME	HEALTH CARD NUMBER	CODE	SEX	BIRTH DATE DD MM YYYY	AGE	SMOKER? NO. OF CIGARETTES DAILY	HEIGHT (cm/inch)	WEIGHT (kg/lb)	WEIGHT CHANGE IN LAST YEAR GAIN	LOSS	REASON
APPLICANT			00									
CO-APPLICANT			01									
DEPENDANT CHILD			02									
DEPENDANT CHILD			02									
DEPENDANT CHILD			02									
DEPENDANT CHILD			02									