Equitable Life of Canada®

Head Office
One Westmount Road North
P.O. Box 1603 Stn Waterloo, Waterloo Ontario N2J 4C7
TF 1.866.963.2246 **T** 519.883.7409
Email coverage2go@equitable.ca

COVERAGE2GO APPLICATION FOR COVERAGE

1. ABOUT YOU

Applicant Name (Please Print) (First, Middle, Last)

Street Address	City	Province	Postal Code

Phone Number	Email Address

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	Preferred Language: ☐ English ☐ French

To be eligible for Coverage2go without any medical questions, you must apply within 60 days of your Group Benefits plan coverage ending. If you apply between 61 and 90 days after your Group Benefits plan coverage ends, you will be required to complete a medical questionnaire to determine your eligibility. You will not be eligible for Coverage2go if you apply more than 90 days after your Group Benefit plan coverage ends.

a) Employer Name: ______________________________

b) Name of Group Benefits Insurance Company: ______________________________

c) Policy Number: ______________________________

d) Your Termination Date from the Plan (Last Day of Coverage) ______________________________

e) Previous Group Benefits Plan: ☐ Health Benefits ☐ Dental Benefits

f) Dependent coverage with previous Group Benefits Plan?: ☐ Yes ☐ No

2. YOUR DEPENDENTS

Children age 21 or older must be registered as a Full Time student or qualify as a Disabled Dependent.

Full Name of Spouse or Partner (Common-Law): (First, Middle, Last)	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):	
Full Name of Child: (First, Middle, Last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled **or** ☐ Full Time Student
Full Name of Child: (First, Middle, Last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled **or** ☐ Full Time Student
Full Name of Child: (First, Middle, Last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled **or** ☐ Full Time Student
Full Name of Child: (First, Middle, Last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled **or** ☐ Full Time Student
Full Name of Child: (First, Middle, Last)	☐ Male ☐ Female	Date of Birth: (MM/DD/YYYY)	☐ Disabled **or** ☐ Full Time Student

COVERAGE2GO APPLICATION FOR COVERAGE

3. CONFIRMATION OF PROVINCIAL HEALTH COVERAGE (E.G. OHIP)

You and your dependents must be covered by your provincial health plan (e.g. OHIP, AHIP, MSP) to be eligible for Coverage2go.*

Residents of British Columbia, Manitoba and Saskatchewan MUST submit a copy of their Provincial Ministry Letter to provide proof that you (and dependents) have registered for Provincial Drug Coverage. This documentation is required to ensure you (and your dependents) have access to the maximum prescription drug coverage available.

If not registered, you must register for the Provincial Drug Coverage Program and attach a copy of the Provincial Ministry letters or documents that provide proof of registration.

*Quebec residents are not eligible for Coverage2go

4. YOUR OPTIONS

I am applying for:

☐ Coverage2go® ☐ Coverage2go with Dental ☐ Coverage2go+ ☐ Coverage2go+ with Dental

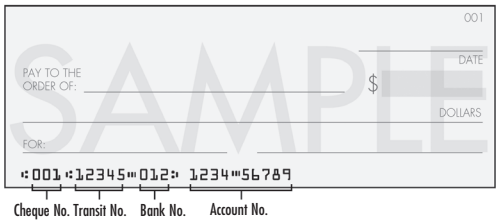
5. PREMIUM PAYMENT INFORMATION, AUTHORIZATION, AND CLAIM PAYMENTS

I authorize Equitable Life to deposit Group Claim payments directly into my bank account.

Bank Name

Bank's Transit Number (5 digits)	Bank Number (3 digits)

Account Number (5-12 digits)



Start of Insurance Coverage

I understand that coverage under a policy will not become effective until my Application is approved by Equitable Life and the first premium payment is honoured by my financial institution.

Pre-Authorized Debit ("PAD") for the First and Subsequent Premium Payments

Equitable Life and my financial institution are directed and authorized to process withdrawals from my bank account indicated above for the initial premium payment and for each subsequent premium payment, on a monthly basis, subject to the conditions below, on the **closest date** prior to the effective date of coverage. Your exact withdrawal date will be provided in your welcome notification once your plan has been set up.

Where the withdrawal date occurs on a weekend or holiday, the withdrawal will be made the next business day.

Note: In the event of non-payment due to insufficient funds, an attempt to re-draw your payment will automatically occur within 2 – 10 business days from the withdrawal date. You are responsible for any NSF charges incurred by your financial institution.

I waive the right to receive pre-notification of the first withdrawal, any increases in the fixed amount of the withdrawal or a change in the date of the withdrawal.

For the purposes of this agreement, all PAD withdrawals from this bank account will be treated as personal withdrawals of insurance premiums, as defined by the Canadian Payments Association in Rule H1 at www.payments.ca.

Contact your financial institution about your rights regarding cancellation. I have the right to cancel this PAD at any time. This PAD shall remain in effect until I notify Equitable Life of cancellation. **Note: To ensure cancellation of the next withdrawal, notice by way of telephone, letter, email or fax must be received at Equitable Life's Head Office 10 business days prior to the next withdrawal.** Any cancellation of this PAD will not affect the policy contract between you and Equitable Life so long as payment is provided by an alternate method within the period specified in your policy contract.

Claim Payments

All claim payments will be deposited to the above account.

6. TERMS AND CONDITIONS

The personal information willingly provided by me to Equitable Life, collected on this Application and held in their files, will be used by Equitable Life for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Coverage2go Policy and all benefits under the Policy, and any supplementary documents.

I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize. If applying for my spouse and/or Dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes.

I consent to my employer/association/organization or former employer/association/organization and the current or recently ended Group Benefits Plan provider (insurance company) providing confirmation of insurance coverage under the current or recently ended Group Benefits Plan for myself, my spouse and/or my Dependents.

I understand that all claims made under the Coverage2go Policy are submitted through me as the policy owner. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or Dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim. I understand that all claims payments will be deposited to the bank account provided in Section 5 of this Application.

I understand that by providing an email address, I am giving Equitable Life permission to communicate with me through email.

I understand that coverage under a policy will not become effective until my Application is approved by Equitable Life and the first premium payment is honoured by my financial institution.

By checking the acknowledgement box below, you confirm that the person(s) listed on this Application is/are authorized to make withdrawals from the above account, and all terms and conditions in this Application are understood and agreed to.

All facts, statements, information and answers given on this Application are true, correct and complete. Any misrepresentation or misstatement of any facts, statements, information or answers given and contained in this Application shall render any insurance issued in connection with this application voidable by Equitable Life.

☐ **Check to confirm and acknowledge your agreement with the above.**

Date: _____
MM/DD/YYYY

Please note: Equitable Life cannot ensure the privacy and confidentiality of any information sent through the internet because e-mail may be vulnerable to interception. As a result, Equitable Life is not responsible for any loss or damages you may incur if your information is intercepted and misused. If you would prefer to submit your information by another means, please contact us at 1.866.963.2246.