National Office
205 Placer Court
Toronto, ON M2H 3H9

UNIFOR
theUnion | lesyndicat

Bureau national
205 Placer Court
Toronto, Ontario M2H3H9

Jerry Dias
National President
Président National

Renaud Gagné
Quebec Director
Directeur Québécois

Peter Kennedy
National Secretary-Treasurer
Secrétaire-trésorier national

September 16, 2015

Greetings,

To: Unifor National Representatives (Service), Local Union Presidents

Several local union leaders and National Service reps have asked about individual health and dental plans for Unifor members where the employer does not provide a plan. We have worked with Green Shield Canada (GSC) on this issue and can offer the Link and Zone benefit plans.

Link is for members who have an employer health care plan and are either terminated or retiring. They do not have to complete a medical questionnaire for the Link benefits as Link offers guaranteed acceptance, if application is submitted within 60 days of losing their group benefits.

If a member does not currently have group coverage, they can apply for the Zone benefits. The Zone plan offers six benefit options, three of which will require a medical questionnaire.

Individual coverage is, of course, more costly than an employer-sponsored plan that covers the whole workforce and the health care risks are shared across a large group. But, there is much to recommend the GSC Link and Zone individual plans:

- GSC is non-profit so the costs are reduced compared to other for-profit carriers
- The Link and Zone plans are pooled with other insured individuals in the plan thus keeping premiums affordable
- The plans have easy to use websites with immediate quotes
- GSC is unionized with Unifor members
- GSC has agreed to offer a program where, if possible, Unifor can negotiate employer contributions toward the Link and Zone plans

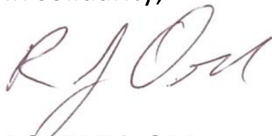
Again, the best health care plan for our members is an employer-sponsored health care plan for the bargaining unit. But where that is not possible, the GSC individual plans are an alternative.

The Zone and Link plans do not offer disability or life insurance benefits.

If you would like an electronic copy of the Zone and Link brochures or a hardcopy, please contact Nasra Mussa (Nasra.Mussa@unifor.org). You can also contact Unifor Pension and Benefit Director, Jo-Ann Hannah (Jo-Ann.Hannah@unifor.org), if you have additional questions. Or speak directly with the GSC Distributor, Prosum Health at 1-855-751-6590.

I also encourage you to invite GSC to meet with employers in your larger units where we do have employer-sponsored plans to discuss the advantages of GSC as a carrier. GSC is an excellent carrier and has many cost-effective controls within the plan to ensure that our members get their benefits and the employer has reasonable costs. Unifor has a long and special relationship with GSC.

In solidarity,



ROBERT J. ORR
Assistant to the
National Secretary-Treasurer

RJO:JH:nmcope343

cc: J. Hannah, Pensions Department staff, Domenic Servideo (domenic.servideo@greenshield.ca), Mary Kerr (mary.kerr@greenshield.ca)

APPLICATION

FOR INDIVIDUAL HEALTH AND DENTAL COVERAGE

SECTION A MAILING ADDRESS AND CONTACT INFORMATION

LAST NAME:	FIRST NAME:	INITIAL:
STREET ADDRESS:		APT. NO:
CITY/TOWN:	PROVINCE:	POSTAL CODE:
HOME TEL: ( )	BUSINESS TEL: ( )	CELL: ( )
EMAIL ADDRESS:		

SECTION B COVERAGE INFORMATION

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

- ☐ **Single coverage** *Applies to applicant only*
- ☐ **Couple coverage** *Applies to applicant and spouse/partner* **OR** *applicant and one dependent child under age 21*
- ☐ **Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

A: Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No

B: If yes, please indicate if coverage was: ☐ Group ☐ Individual

C: When did your coverage end? YYYY/MM/DD:

D: Name of insurance carrier:

Select one plan option:

- ☐ **LINK 1**
- ☐ **LINK 2**
- ☐ **LINK 3**
- ☐ **LINK 4**

TOTAL MONTHLY PREMIUM:

$

SECTION C INDIVIDUALS TO BE COVERED

LAST NAME	FIRST NAME	INITIAL	GENDER	DATE OF BIRTH YYYY/MM/DD	AGE
APPLICANT:			☐ MALE ☐ FEMALE		
SPOUSE/PARTNER:			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

FOR ADVISOR USE ONLY

ADVISOR CODE:	ADVISOR NAME:
OFFICE CODE:	OFFICE NAME:
MGA CODE:	MGA NAME:

FOR GSC USE ONLY

ADVISOR CODE:	BD:
OFFICE CODE:	EFFECTIVE DATE:
MGA CODE:	APPROVED BY:

SECTION D PAYMENT INFORMATION

Payment for the first two months of coverage is due on your coverage effective date. Subsequent payments will be made 30 days in advance of the month for which coverage is to be provided. For example, if your coverage is effective on March 1, you would pay for March and April on or about March 1. Depending on how you choose to pay, we will withdraw payment from your bank account or charge your credit card for your May coverage on or about April 1. **Payee contact: healthassist@greenshield.ca or 1.855.722.0472**

METHOD OF PAYMENT

☐ Pre-authorized Credit Card ☐ Mastercard ☐ Visa ☐ American Express

Name (as it appears on card): Credit Card Number: Expiry:

ADDRESS: CITY/TOWN: PROVINCE: POSTAL CODE:

☐ Pre-authorized Debit **PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID" – Applications received without a "VOID" cheque cannot be processed.**

Is this account Personal or Business? ☐ Personal ☐ Business

Is this a joint account? ☐ Yes ☐ No If "Yes", does this joint account require more than one signature? ☐ Yes ☐ No

If two signatures are required, information for both Account Holders must be provided:

1st Account Holder			2nd Account Holder		
NAME:			NAME:		
ADDRESS:			ADDRESS (IF DIFFERENT FROM 1ST PAYOR):		
CITY/TOWN:	PROVINCE:	POSTAL CODE:	CITY/TOWN:	PROVINCE:	POSTAL CODE:
TELEPHONE NUMBER: ( )			TELEPHONE NUMBER: ( )		

PAYMENT AUTHORIZATION

I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.cdnpay.ca.

I/We hereby authorize GSC to withdraw premium payments from the account specified above on or about the first business day of the month as outlined above.

Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change.

GSC may terminate coverage in the event that a premium withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur.

I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.cdnpay.ca.

I/We represent and warrant that the payment information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

Signature of Account Holder: .... DATE YYYY/MM/DD: ....

2nd Signature (if joint account): .... DATE YYYY/MM/DD: ....

SECTION E DECLARATIONS AND AUTHORIZATIONS

NOTE: THIS AUTHORIZATION MUST BE SIGNED BY THE APPLICANT AND SPOUSE/PARTNER (IF APPLICABLE). THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL.

- By signing this application form, I/we agree that the statements contained herein are true and complete, to the best of my/our knowledge and form the basis for any coverage approved.
- I am authorized to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits.
- I/We understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependent children could result in denial of a claim and the cancellation or modification of this coverage.
- I/We understand that it is my/our obligation to notify GSC 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.
- 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 dependent children, to exchange such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with GSC.
- A reproduction of this consent and authorization shall be as valid as the original.

Signature of applicant: .... DATE YYYY/MM/DD: ....

Signature of spouse/partner: .... DATE YYYY/MM/DD: ....

GSC'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 information on GSC's privacy policies and procedures, visit greenshield.ca.

BENEFIT DESCRIPTIONS

PRESCRIPTION DRUGS

Prescription drugs approved for use in Canada that require a prescription by law and have been prescribed by an authorized medical practitioner.

Smoking cessation products and drugs for the treatment of obesity, infertility and erectile dysfunction are not covered.

For Quebec residents: To be eligible for the GSC drug plan, you must be covered by the RAMQ (Régie de l'assurance maladie du Québec) plan. Amounts not paid by RAMQ, including the drug plan co-pay and the deductible (regardless of age) are eligible expenses under your GSC drug plan.

DENTAL

SCHEDULE A – BASIC SERVICES

Preventive cleaning
Routine examinations, x-rays
Fillings and extractions
Fluoride treatment for children

SCHEDULE B – COMPREHENSIVE BASIC SERVICES

Endodontic treatment – root canal therapy
Periodontal treatment – scaling and root planing, occlusal adjustment and equilibration
Denture repairs, rebasing and relining

SCHEDULE C – MAJOR SERVICES

Payable in Year 3
Crowns and onlays
Dentures
Bridgework

SCHEDULE D – ORTHODONTIC SERVICES

Payable in Year 3
Orthodontic treatment to straighten teeth and correct the bite

EXTENDED HEALTH

Medical Items include:

Aids for daily living
Braces, casts, catheters and ostomy supplies
Compression stockings
Diabetic supplies
Custom made boots or shoes, custom made foot orthotics
Mobility aids (such as canes, crutches, walkers, wheelchairs)
Prosthetics
Respiratory/Cardiology items (such as breathing and heart monitors for infants, compressors, oxygen)

POWERED BY

healthassist

healthassist	LINK 1	LINK 2	LINK 3	LINK 4
PRESCRIPTION DRUGS				
Maximums	$500 per year Paid at 80% Brand name drugs covered if no generic equivalent exists	$750 per year Paid at 80% Brand name drugs covered if no generic equivalent exists	$1,200 per year Paid at 80% Brand name drugs covered if no generic equivalent exists	$2,000 per year Paid at 80% Brand name drugs covered if no generic equivalent exists
DENTAL				
Maximums	Not Covered	Year 1: $600 Year 2: $800 Year 3+: $1,000 per year thereafter	Year 1: $750 Year 2: $1,000 Year 3+: $1,250 per year thereafter	Year 1: $1,000 Year 2: $1,250 Year 3+: $1,750 per year thereafter
Recall Frequency	Not Covered	9 month	9 month	6 month
Schedule A Basic Services	Not Covered	Paid at 80%	Paid at 80%	Paid at 80%
Schedule B Comprehensive Basic Services	Not Covered	Paid at 80%	Paid at 80%	Paid at 80%
Schedule C Major Services	Not Covered	Not Covered	Paid at 50%, starting in the 3rd benefit year	Paid at 50%, starting in the 3rd benefit year
Schedule D Orthodontic Services	Not Covered	Not Covered	Not Covered	Paid at 50%, starting in the 3rd benefit year $2,000 lifetime maximum
EXTENDED HEALTH				
Vision	$150 every 24 months	$200 every 24 months	$250 every 24 months	$300 every 24 months
Accidental Dental	$2,500 per year	$5,000 per year	$10,000 per year	$10,000 per year
Ambulance Transportation	Includes land and air	Includes land and air	Includes land and air	Includes land and air
Hearing Aids	$300 every 4 years	$400 every 4 years	$500 every 4 years	$600 every 4 years
Home Support Services	$1,500 per year	$2,500 per year	$5,000 per year	$5,000 per year
Medical Items	$1,500 per year	$2,500 per year	$5,000 per year	$5,000 per year
Professional Services **Registered Therapists** Maximum per practitioner				
Chiropractor, Chiropodist/Podiatrist, Naturopath, Osteopath, Physiotherapist	$20 per visit; 15 visits per year	$300 per year	$400 per year	$600 per year per practitioner up to $1,200 per year combined
Massage Therapist , Acupuncturist	$20 per visit; 15 visits per year	$20 per visit; 15 visits per year	$20 per visit; 20 visits per year	$30 per visit; 20 visits per year
Psychologist, Registered Social Worker	$600 per year combined	$600 per year combined	$600 per year combined	$600 per year combined
Speech Therapist	$300 per year	$300 per year	$400 per year	$600 per year
Eye Examinations	$50 every 24 months	$50 every 24 months	$65 every 24 months	$80 every 24 months
Emergency Travel Out of Province/ Country coverage	$1,000,000 per year 10 days per trip	$1,000,000 per year 10 days per trip	$1,000,000 per year 15 days per trip	$1,000,000 per year 15 days per trip
Hospital Accommodation (Semi-Private and/or Private)	$200 per day 30 days per year	$200 per day 30 days per year	$200 per day 30 days per year	$250 per day 30 days per year

LEGAL ASSISTANCE BENEFIT AND ACCESS TO AN ONLINE WELLNESS RESOURCE LIBRARY INCLUDED IN ALL PLANS

This plan comparison is a summary and does not constitute a contract. Actual terms, conditions, limitations and exclusions are detailed in the contract issuesd by GSC upon application approval. All Maximums shown are per covered person. Reimbursement will be made for eligible expenses incurred, paid for and received by the covered person provided such services and supplies are, in the opinion of GSC, medically necessary for the treatment of an illness or injury and reasonable and customary, taking all factors into account. Coverage amounts shown are in Canadian Dollars. Premiums and/or benefits are subject to change with thirty (30) days written notice. If you have any questions or require more information, please contact your Benefits Advisor.

*Quebec residents can be covered up to 100% only if the drug is listed on the RAMQ formulary. If the drug is not covered by RAMQ, the standard co-pay applies.

LINK RATES

POWERED BY

gsc

green shield canada

healthassist

MONTHLY PREMIUMS FOR RESIDENTS OF:		BRITISH COLUMBIA			ALBERTA			SASKATCHEWAN, MANITOBA NORTHWEST TERRITORIES YUKON TERRITORY AND NUNAVUT TERRITORY			ONTARIO			NEW BRUNSWICK NOVA SCOTIA PRINCE EDWARD ISLAND AND NEWFOUNDLAND AND LABRADOR			QUEBEC		
	AGE	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY
LINK 1	0-44	$64	$120	$168	$64	$120	$168	$61	$112	$156	$78	$145	$204	$76	$140	$196	$78	$145	$204
	45-54	$79	$147	$207	$79	$147	$207	$73	$136	$191	$95	$176	$249	$92	$169	$241	$95	$176	$249
	55-64	$87	$160	$227	$87	$160	$227	$80	$145	$205	$105	$192	$274	$100	$185	$261	$105	$192	$274
	65+	$71	$131	$178	$71	$131	$178	$65	$119	$160	$85	$156	$213	$82	$151	$204	$85	$156	$213
LINK 2	0-44	$116	$216	$312	$118	$220	$322	$92	$170	$247	$136	$255	$368	$118	$220	$321	$128	$239	$340
	45-54	$129	$241	$343	$131	$245	$347	$100	$189	$267	$150	$282	$399	$133	$246	$344	$141	$262	$372
	55-64	$139	$256	$360	$141	$261	$372	$107	$200	$282	$162	$300	$424	$141	$262	$372	$151	$278	$393
	65+	$105	$194	$275	$107	$200	$279	$84	$155	$218	$123	$227	$319	$108	$201	$282	$117	$215	$301
LINK 3	0-44	$150	$282	$415	$147	$276	$406	$120	$221	$324	$168	$315	$463	$151	$283	$412	$160	$297	$439
	45-54	$175	$326	$483	$170	$318	$473	$138	$257	$375	$196	$366	$537	$176	$331	$483	$187	$349	$514
	55-64	$191	$361	$529	$186	$349	$517	$152	$283	$413	$215	$403	$586	$192	$362	$529	$206	$383	$564
	65+	$140	$261	$373	$135	$249	$356	$109	$203	$287	$156	$288	$415	$139	$261	$368	$149	$276	$394
LINK 4	0-44	$174	$327	$481	$170	$319	$469	$157	$291	$427	$194	$364	$534	$177	$330	$481	$178	$330	$489
	45-54	$204	$379	$561	$197	$368	$548	$183	$341	$500	$227	$424	$621	$205	$388	$565	$208	$389	$572
	55-64	$221	$420	$614	$215	$403	$598	$201	$376	$549	$248	$467	$678	$225	$423	$619	$230	$428	$628
	65+	$171	$319	$458	$164	$302	$433	$141	$263	$374	$194	$361	$515	$182	$341	$484	$183	$340	$487

DEFINITIONS:

Single: applies to applicant only.

Couple: applies to applicant and spouse/partner **OR** applicant and one dependent child under age 21.

Family: applies to applicant and spouse/ partner and dependent children under age 21.

NOTE: Rates are effective January 1, 2014. Premiums and/or benefits are subject to change with thirty (30) days written notice to the applicant.

MAKE THE LINK

WITH A COMPREHENSIVE HEALTH PLAN THAT IS...

- → SIMPLE TO UNDERSTAND
- → SIMPLE TO APPLY FOR
- → SIMPLE TO USE

Let us show you...

EASY
No medical questionnaire when you transfer from any group insurance plan within 60 days from the end of coverage.

SIMPLE PLAN OPTIONS
Just select the plan that best suits your needs.

NO WAITING PERIOD
Coverage begins the first of the month following approval.

BENEFITS FOR LIFE
If you sign up before you are 80, you have coverage as long as you need it (as long as you pay your monthly premiums, of course).

INCREASING MAXIMUMS
The longer you're on the plan, the better your coverage.

NO PAPERWORK (ALMOST)
Pay-direct card for use at most pharmacies and hospitals, as well as dental, vision and paramedical practitioner offices—virtually no paper claims.

CONVENIENCE WITH MINIMAL OUT-OF-POCKET EXPENSES

Most health service providers can submit your claims online, check eligibility and print statements.

INFORMATION AT YOUR FINGERTIPS

Check your coverage (yes, even for drugs), set up direct deposit, print premium confirmations, find a provider, and more – all online!

TRAVEL COVERAGE INCLUDED

Emergency travel benefits and out-of-country assistance – it's all part of the plan.

LEGAL ASSISTANCE

Legal advice toll-free anywhere in Canada 24/7.

WELLNESS RESOURCE LIBRARY

Online access to an extensive range of health topics.

WIN WIN FOR BUSINESS OWNERS

Premiums may be a tax deductible business expense.

And of course, service with a smile

It just wouldn't be from GSC, if it didn't come with over-the-top customer service – we've got the knowledge to answer your questions, and a personality too!

Even more to feel good about…

As Canada's only national not-for-profit health and dental specialist, with GSC you receive comprehensive coverage while being part of something bigger. We enhance the greater good through charitable giving for initiatives that improve access to better health. And it doesn't hurt that this allows us to offer very competitive rates!

gsc healthassist LINK

APPLICATION

FOR INDIVIDUAL HEALTH AND DENTAL COVERAGE

SECTION A MAILING ADDRESS AND CONTACT INFORMATION

LAST NAME:	FIRST NAME:	INITIAL:
STREET ADDRESS:		APT. NO:
CITY/TOWN:	PROVINCE:	POSTAL CODE:
HOME TEL: ( )	BUSINESS TEL: ( )	CELL: ( )
EMAIL ADDRESS:		

SECTION B COVERAGE INFORMATION

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

☐ **Single coverage** *Applies to applicant only*

☐ **Couple coverage** *Applies to applicant and spouse/partner* **OR** *applicant and one dependent child under age 21*

☐ **Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

A: Are you covered, or were you covered under any other health plan? ☐ Yes ☐ No

B: If yes, please indicate if coverage was: ☐ Group ☐ Individual

C: When did your coverage end? YYYY/MM/DD:

D: Name of insurance carrier:

Select one plan option:

☐ **ZONE 1**
☐ **ZONE 2**
☐ **ZONE 3**
☐ **ZONE 4**
☐ **ZONE 5**
☐ **ZONE 6**

Add optional Hospital Accommodation
☐ Yes ☐ No

TOTAL MONTHLY PREMIUM:

$

SECTION C INDIVIDUALS TO BE COVERED

LAST NAME	FIRST NAME	INITIAL	GENDER	DATE OF BIRTH YYYY/MM/DD	AGE
APPLICANT:			☐ MALE ☐ FEMALE		
SPOUSE/PARTNER:			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		
DEPENDENT CHILD: *(must be under age 21)*			☐ MALE ☐ FEMALE		

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

FOR ADVISOR USE ONLY

ADVISOR CODE:	ADVISOR NAME:
OFFICE CODE:	OFFICE NAME:
MGA CODE:	MGA NAME:

FOR GSC USE ONLY

ADVISOR CODE:	BD:
OFFICE CODE:	EFFECTIVE DATE:
MGA CODE:	APPROVED BY:

Complete SECTION D if you are applying for Zone 4, 5 or 6 **OR** if you have selected the optional Hospital Accommodation benefit. Otherwise, proceed to SECTION E.

SECTION D STATEMENT OF HEALTH AND PRESCRIPTION DRUG INFORMATION

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

		APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
A:	Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures or paralysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B:	ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C:	Stomach, intestinal, kidney, bladder or liver disorder including hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D:	Infertility, reproductive disorder or menopause	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E:	Colitis, Crohn's, irritable bowel syndrome, ulcers, hernia, reflux or persistent heartburn	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
F:	Circulatory, heart or vascular disease, high blood pressure, angina, stroke or TIA (mini-stroke)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
G:	Elevated cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
H:	Alcoholism or drug dependency	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
I:	Skin disorders including acne, rosacea, psoriasis or eczema	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
J:	AIDS, ARC (AIDS related complex), HIV or other immunological disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
K:	Arthritis/rheumatism, osteoporosis, bone density loss, back, joint or muscle pain	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
L:	Lung condition, respiratory conditions including COPD, asthma or allergies	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
M:	Headaches or migraines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N:	Cancer, tumor or leukemia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
O:	Sexually transmitted diseases or infections (STDs or STIs) or recurring infections including cold sores or herpes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
P:	Diabetes, endocrine, hormonal or thyroid disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Q:	Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
R:	Other condition, disease, disorder or injury not listed above – please check (✔) Applicant, Spouse/Partner or Dependent(s) and specify below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to any condition(s) in SECTION D-1 above, please identify which question [letter(s) A–R] and provide details below:

QUESTION LETTER	FIRST NAME OF PERSON	DATE(S) DIAGNOSED YYYY/MM	DRUGS / TREATMENT	NATURE OF ILLNESS, INJURY OR CONDITION AND RESULTS OF TREATMENT

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

SECTION D CONTINUED...

2 Do you, your spouse/partner and/or any listed dependent children currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? ☐ Yes ☐ No
Prescription drugs include oral medications, injectables, creams, drops or serum.

If you answered "Yes" to this question, please provide details below:

PRESCRIPTION DRUG INFORMATION

FIRST NAME OF PERSON	NAME OF DRUG	STRENGTH	DAILY DOSAGE	LENGTH OF TIME USING THIS DRUG	NUMBER OF REFILLS PER YEAR	DATE OF LAST REFILL YYYY/MM/DD

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

	APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
3 Have you, your spouse/partner and/or any listed dependent children been hospitalized in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4 Do you, your spouse/partner and/or any listed dependent children expect to be hospitalized in the next six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to question 3 or 4, please provide details below:

FIRST NAME OF PERSON	DATE OF ILLNESS, INJURY OR CONFINEMENT YYYY/MM	ACTUAL OR ANTICIPATED NUMBER OF DAYS IN HOSPITAL	DETAILS/OUTCOME OF ILLNESS OR INJURY

NOTE: IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH A SEPARATE SIGNED AND DATED SHEET.

	APPLICANT	SPOUSE / PARTNER	DEPENDENT(S)
5 Have you, your spouse/partner and/or any listed dependent children consulted a physician annually over the last two (2) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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: ( )

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

SECTION E PAYMENT INFORMATION

Payment for the first two months of coverage is due on your coverage effective date. Subsequent payments will be made 30 days in advance of the month for which coverage is to be provided. For example, if your coverage is effective on March 1, you would pay for March and April on or about March 1. Depending on how you choose to pay, we will withdraw payment from your bank account or charge your credit card for your May coverage on or about April 1. **Payee contact: healthassist@greenshield.ca or 1.855.722.0472**

METHOD OF PAYMENT

☐ Pre-authorized Credit Card ☐ Mastercard ☐ Visa ☐ American Express

Name (as it appears on card): Credit Card Number: Expiry:

ADDRESS: CITY/TOWN: PROVINCE: POSTAL CODE:

☐ Pre-authorized Debit **PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID" – Applications received without a "VOID" cheque cannot be processed.**

Is this account Personal or Business? ☐ Personal ☐ Business

Is this a joint account? ☐ Yes ☐ No If "Yes", does this joint account require more than one signature? ☐ Yes ☐ No

If two signatures are required, information for both Account Holders must be provided:

1st Account Holder	2nd Account Holder
NAME:	NAME:
ADDRESS:	ADDRESS (IF DIFFERENT FROM 1ST PAYOR):
CITY/TOWN: PROVINCE: POSTAL CODE:	CITY/TOWN: PROVINCE: POSTAL CODE:
TELEPHONE NUMBER: ( )	TELEPHONE NUMBER: ( )

PAYMENT AUTHORIZATION

I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.cdnpay.ca.

I/We hereby authorize GSC to withdraw premium payments from the account specified above on or about the first business day of the month as outlined above.

Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change.

GSC may terminate coverage in the event that a premium withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur.

I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.cdnpay.ca.

I/We represent and warrant that the payment information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

Signature of Account Holder: .... DATE YYYY/MM/DD: ....

2nd Signature (if joint account): .... DATE YYYY/MM/DD: ....

SECTION F DECLARATIONS AND AUTHORIZATIONS

NOTE: THIS AUTHORIZATION MUST BE SIGNED BY THE APPLICANT AND SPOUSE/PARTNER (IF APPLICABLE). THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL.

- By signing this application form, I/we agree that the statements contained herein are true and complete, to the best of my/our knowledge and form the basis for any coverage approved.
- I am authorized to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits.
- I/We understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependent children could result in denial of a claim and the cancellation or modification of this coverage.
- I/We understand that it is my/our obligation to notify GSC 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.
- 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 dependent children, to exchange such information as is needed to administer benefit claims and/or to confirm the accuracy of the information with GSC.
- A reproduction of this consent and authorization shall be as valid as the original.

Signature of applicant: .... DATE YYYY/MM/DD: ....

Signature of spouse/partner: .... DATE YYYY/MM/DD: ....

GSC'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 information on GSC's privacy policies and procedures, visit greenshield.ca.

BENEFIT DESCRIPTIONS

PRESCRIPTION DRUGS

Prescription drugs approved for use in Canada that require a prescription by law and have been prescribed by an authorized medical practitioner.

Brand name drugs covered if no generic equivalent exists.

Smoking cessation products and drugs for the treatment of obesity, infertility and erectile dysfunction are not covered.

For Quebec residents: To be eligible for the GSC drug plan, you must be covered by the RAMQ (Régie de l'assurance maladie du Québec) plan. Amounts not paid by RAMQ, including the drug plan co-pay and the deductible (regardless of age) are eligible expenses under your GSC drug plan.

DENTAL

SCHEDULE A – BASIC SERVICES

Preventive cleaning
Routine examinations, x-rays
Fillings and extractions
Fluoride treatment for children

SCHEDULE B – COMPREHENSIVE BASIC SERVICES

Endodontic treatment – root canal therapy
Periodontal treatment – scaling and root planing, occlusal adjustment and equilibration
Denture repairs, rebasing and relining

SCHEDULE C – MAJOR SERVICES

Payable in Year 3
Crowns and onlays
Dentures
Bridgework

EXTENDED HEALTH

MEDICAL ITEMS INCLUDE:

Aids for daily living
Braces, casts, catheters and ostomy supplies
Compression stockings
Diabetic supplies
Custom made boots or shoes, custom made foot orthotics
Mobility aids (such as canes, crutches, walkers, wheelchairs)
Prosthetics
Respiratory/Cardiology items (such as breathing and heart monitors for infants, compressors, oxygen)

POWERED BY

ZONE PLANS

healthassist

healthassist

	ZONE 1 HEALTH	ZONE 2 DENTAL / HEALTH	ZONE 3 DENTAL / HEALTH	ZONE 4 DRUG / HEALTH	ZONE 5 DRUG / DENTAL / HEALTH	ZONE 6 DRUG / DENTAL / HEALTH
	NO MEDICAL UNDERWRITING REQUIRED			MEDICAL UNDERWRITING REQUIRED		
PRESCRIPTION DRUGS						
Maximum	Not included	Not included	Not included	$2,500 per year Paid at 80% (100% in Quebec*) Pay-Direct card	$5,000 per year Paid at 90% (100% in Quebec*) Pay-Direct card	$10,000 per year Paid at 90% (100% in Quebec*) Pay-Direct card
DENTAL						
Maximums	Not included	Year 1: $500 Year 2: $650 Year 3+: $800 per year thereafter	Year 1: $600 Year 2: $800 Year 3+: $1,000 per year thereafter	Not included	Year 1: $700 Year 2: $900 Year 3+: $1,100 per year thereafter	Year 1: $800 Year 2: $1,000 Year 3+: $1,300 per year thereafter
Recall Frequency	Not included	9 month	9 month	Not included	9 month	6 month
Schedule A Basic Services	Not included	Paid at 80%	Paid at 80%	Not included	Paid at 80%	Paid at 80%
Schedule B Comprehensive Basic Services	Not included	Year 1: Paid at 50% Year 2: Paid at 70% Year 3+: Paid at 80%	Paid at 80%	Not included	Year 1: Paid at 60% Year 2: Paid at 70% Year 3+: Paid at 80%	Paid at 80%
Schedule C Major Services	Not included	Not included	Available in Year 3 Paid at 50%	Not included	Available in Year 3 Paid at 50%	Available in Year 3 Paid at 50%
EXTENDED HEALTH						
Accidental Dental	$5,000 per year	$5,000 per year	$5,000 per year	$5,000 per year	$10,000 per year	$10,000 per year
Ambulance Transportation	Includes land and air	Includes land and air	Includes land and air	Includes land and air	Includes land and air	Includes land and air
Hearing Aids	Year 1-4: $300 every 4 years Year 5+: $400 every 4 years thereafter	Year 1-4: $300 every 4 years Year 5+: $400 every 4 years thereafter	Year 1-4: $350 every 4 years Year 5+: $500 every 4 years thereafter	Year 1-4: $350 every 4 years Year 5+: $500 every 4 years thereafter	$500 every 4 years	$500 every 4 years
Medical Services Diagnostic tests and x-rays, dialysis equipment laboratory tests	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
Medical Items and Home Support Services (in home nursing) Separate maximums for Medical Items and Home Support Services	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per year thereafter	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per year thereafter	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per year thereafter	Year 1: $2,000 Year 2: $3,000 Year 3: $4,000 Year 4+: $5,000 per year thereafter	Year 1: $2,000 Year 2: $4,000 Year 3+: $6,000 per year thereafter	Year 1: $2,000 Year 2: $4,000 Year 3+: $6,000 per year thereafter
Professional Services/Registered Therapists Maximums per practitioner						
Acupuncturist, Chiropractor Chiropodist/Podiatrist Massage Therapist Naturopath, Osteopath Physiotherapist	$300 per year $20 per visit	$300 per year $20 per visit	$400 per year $20 per visit	$400 per year $20 per visit	$500 per year $25 per visit	$600 per year $25 per visit
Psychologist, Speech Therapist	$300 per year	$300 per year	$400 per year	$400 per year	$500 per year	$600 per year
Vision Prescription eyeglasses contact lenses, laser eye surgery	$150 every 2 years	$150 every 2 years	$150 every 2 years	$150 every 2 years	Year 1-2: $150 every 2 years Year 3-4: $200 every 2 years Year 5+: $250 every 2 years thereafter	Year 1-2: $200 every 2 years Year 3-4: $250 every 2 years Year 5+: $300 every 2 years thereafter
Eye Examination	$65 every 2 years	$65 every 2 years	$65 every 2 years	$65 every 2 years	$80 every 2 years	$80 every 2 years
Emergency Travel Out of Province/Country coverage	First 15 days of trip $1,000,000 per year	First 15 days of trip $1,000,000 per year	First 15 days of trip $1,000,000 per year	First 15 days of trip $1,000,000 per year	First 30 days of trip $1,000,000 per year	First 30 days of trip $1,000,000 per year

OPTIONAL SEMI-PRIVATE HOSPITAL ACCOMMODATION

Benefit pays for the difference in cost between standard ward charges and semi-private accommodation in a public general hospital for up to 30 days per year; can be added to all plans listed above – medical underwriting required.

Legal Assistance via toll-free telephone and an online **Wellness Resource Library** included in all plans.

This Plan Comparator is a summary and does not constitute a contract. Actual terms, conditions, limitations and exclusions are detailed in the contract issued by GSC upon application approval. All maximums shown are per covered person. Reimbursement will be made for eligible expenses incurred, paid for and received by the covered person provided such services and supplies are, in the opinion of GSC, medically necessary for the treatment of an illness or injury and reasonable and customary, taking all factors into account. Coverage amounts shown are in Canadian Dollars. Premiums and/or benefits are subject to change with thirty (30) days written notice. If you have any questions or require more information, please contact your Benefits Advisor. *Quebec residents can be covered up to 100% only if the drug is listed on the RAMQ formulary. If the drug is not covered by RAMQ, the standard co-pay applies.

DEFINITIONS

Single: applies to applicant only. **Couple:** applies to applicant and spouse/partner **OR** applicant and one dependent child under age 21. **Family:** applies to applicant and spouse/ partner and dependent children under age 21.

NOTE

Rates are effective January 1, 2014. Premiums and/or benefits are subject to change with thirty (30) days written notice to the applicant.

POWERED BY

ZONE RATES

healthassist

MONTHLY PREMIUMS FOR RESIDENTS OF:		BRITISH COLUMBIA			ALBERTA			SASKATCHEWAN, MANITOBA NORTHWEST TERRITORIES YUKON TERRITORY AND NUNAVUT TERRITORY			ONTARIO			NEW BRUNSWICK NOVA SCOTIA PRINCE EDWARD ISLAND AND NEWFOUNDLAND AND LABRADOR			QUEBEC		
	AGE	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY	SINGLE	COUPLE	FAMILY
ZONE 1	18-44	$16.60	$31.80	$40.60	$20.80	$39.70	$51.10	$16.60	$31.80	$40.60	$22.90	$43.70	$56.30	$22.90	$43.70	$56.30	$25.00	$47.70	$61.50
	45-54	$17.70	$33.80	$43.20	$22.20	$42.30	$54.40	$17.70	$33.80	$43.20	$24.40	$46.60	$60.00	$24.40	$46.60	$60.00	$26.60	$50.90	$65.60
	55-59	$18.80	$35.90	$46.00	$23.60	$45.00	$58.00	$18.80	$35.90	$46.00	$26.00	$49.60	$64.00	$26.00	$49.60	$64.00	$28.40	$54.20	$70.00
	60-64	$19.70	$37.70	$48.30	$24.80	$47.30	$61.00	$19.70	$37.70	$48.30	$27.30	$52.10	$67.30	$27.30	$52.10	$67.30	$29.80	$56.90	$73.60
	65+	$22.80	$43.60	$54.90	$28.10	$53.80	$68.30	$22.80	$43.60	$54.90	$30.80	$58.90	$75.00	$30.80	$58.90	$75.00	$33.50	$64.00	$81.70
ZONE 2	18-44	$56.80	$108.20	$141.10	$60.60	$115.40	$150.60	$42.30	$80.60	$104.80	$62.50	$119.00	$155.30	$50.10	$95.30	$124.20	$67.70	$128.90	$168.40
	45-54	$57.80	$110.10	$143.50	$61.90	$117.80	$153.70	$43.30	$82.50	$107.20	$63.90	$121.70	$158.80	$51.50	$98.00	$127.70	$69.20	$131.90	$172.20
	55-59	$58.80	$111.90	$146.00	$63.10	$120.20	$156.90	$44.30	$84.30	$109.70	$65.30	$124.30	$162.30	$52.90	$100.60	$131.20	$70.80	$134.70	$176.10
	60-64	$59.60	$113.50	$148.10	$64.20	$122.20	$159.60	$45.10	$85.90	$111.80	$66.50	$126.60	$165.30	$54.10	$102.90	$134.20	$72.10	$137.30	$179.40
	65+	$62.60	$119.40	$154.50	$67.50	$128.70	$166.70	$48.10	$91.80	$118.20	$69.90	$133.30	$172.80	$57.50	$109.60	$141.70	$75.60	$144.20	$187.20
ZONE 3	18-44	$64.20	$122.20	$159.70	$68.60	$130.50	$170.60	$47.80	$91.00	$118.60	$70.80	$134.70	$176.10	$56.70	$108.00	$140.90	$75.30	$143.40	$187.50
	45-54	$65.40	$124.40	$162.50	$70.10	$133.30	$174.20	$49.00	$93.20	$121.40	$72.40	$137.80	$180.10	$58.30	$111.10	$144.90	$77.10	$146.80	$191.90
	55-59	$66.50	$126.50	$165.30	$71.50	$136.00	$177.80	$50.10	$95.30	$124.20	$74.00	$140.80	$184.10	$59.90	$114.10	$148.90	$78.80	$150.10	$196.30
	60-64	$67.50	$128.40	$167.70	$72.80	$138.50	$181.00	$51.10	$97.20	$126.60	$75.40	$143.50	$187.60	$61.30	$116.80	$152.40	$80.40	$153.00	$200.10
	65+	$70.60	$134.50	$174.50	$76.20	$145.20	$188.60	$54.20	$103.30	$133.40	$79.00	$150.50	$195.60	$64.90	$123.80	$160.40	$84.10	$160.30	$208.50
ZONE 4	18-44	$38.20	$72.80	$94.60	$47.40	$90.20	$117.50	$39.80	$75.80	$98.60	$56.00	$106.60	$139.10	$54.40	$103.60	$135.10	$42.20	$80.30	$104.50
	45-54	$42.50	$80.90	$105.20	$52.70	$100.30	$130.70	$44.30	$84.40	$109.80	$62.40	$118.80	$155.10	$60.60	$115.30	$150.50	$46.40	$88.30	$114.90
	55-59	$48.50	$92.30	$120.20	$60.10	$114.40	$149.30	$50.70	$96.50	$125.70	$71.50	$136.10	$177.80	$69.30	$131.90	$172.30	$51.80	$98.70	$128.60
	60-64	$55.20	$105.00	$136.90	$68.50	$130.30	$170.10	$57.80	$110.10	$143.50	$81.70	$155.50	$203.30	$79.00	$150.40	$196.70	$57.80	$110.00	$143.40
	65+	$47.90	$91.40	$117.70	$59.10	$112.70	$145.70	$49.70	$94.90	$122.30	$69.30	$132.10	$171.30	$67.40	$128.60	$166.70	$53.50	$102.10	$131.80
ZONE 5	18-44	$88.00	$167.70	$218.20	$97.60	$185.80	$242.00	$73.10	$139.30	$180.80	$106.10	$202.00	$263.30	$90.50	$172.50	$224.40	$93.60	$178.30	$232.10
	45-54	$92.20	$175.60	$228.70	$102.80	$195.80	$255.10	$77.60	$147.70	$191.90	$112.40	$214.00	$279.10	$96.60	$184.00	$239.60	$97.90	$186.30	$242.80
	55-59	$98.10	$186.80	$243.40	$110.10	$209.60	$273.40	$83.80	$159.50	$207.50	$121.30	$230.90	$301.40	$105.10	$200.30	$261.00	$103.50	$197.00	$256.70
	60-64	$104.60	$199.10	$259.50	$118.20	$224.80	$293.40	$90.70	$172.60	$224.60	$131.10	$249.50	$325.90	$114.50	$218.10	$284.50	$109.40	$208.10	$271.40
	65+	$100.10	$191.10	$246.50	$111.80	$213.30	$275.60	$85.50	$163.20	$209.70	$122.00	$232.60	$301.10	$106.20	$202.60	$261.60	$107.80	$205.70	$265.70
ZONE 6	18-44	$97.70	$185.90	$242.20	$108.70	$207.00	$269.90	$81.60	$155.30	$202.00	$118.40	$225.30	$294.10	$101.60	$193.30	$252.00	$105.00	$199.80	$260.60
	45-54	$102.40	$195.00	$254.20	$114.70	$218.40	$284.90	$86.60	$164.90	$214.50	$125.60	$239.00	$312.10	$108.50	$206.50	$269.40	$109.90	$209.20	$272.80
	55-59	$109.10	$207.70	$270.90	$123.10	$234.10	$305.70	$93.70	$178.40	$232.20	$135.70	$258.20	$337.40	$118.20	$225.00	$293.70	$116.40	$221.50	$289.10
	60-64	$116.30	$221.30	$288.80	$132.00	$251.00	$327.90	$101.30	$192.80	$251.30	$146.60	$278.90	$364.60	$128.70	$244.80	$319.80	$123.00	$234.10	$305.50
	65+	$111.20	$212.00	$274.10	$124.80	$237.90	$308.10	$95.40	$182.00	$234.50	$136.40	$260.00	$337.10	$119.30	$227.50	$294.30	$121.20	$231.10	$299.10

OPTIONAL SEMI-PRIVATE HOSPITAL ACCOMMODATION MONTHLY PREMIUMS – CAN BE ADDED TO ALL PLANS LISTED ABOVE

AGE	BC SINGLE	BC COUPLE	BC FAMILY	AB SINGLE	AB COUPLE	AB FAMILY	SK/MB/NT/YT/NU SINGLE	SK/MB/NT/YT/NU COUPLE	SK/MB/NT/YT/NU FAMILY	ON SINGLE	ON COUPLE	ON FAMILY	NB/NS/PEI/NL SINGLE	NB/NS/PEI/NL COUPLE	NB/NS/PEI/NL FAMILY	QC SINGLE	QC COUPLE	QC FAMILY
18-44	$4.20	$7.60	$9.70	$5.10	$9.20	$11.70	$4.20	$7.60	$9.70	$6.00	$10.80	$13.80	$5.10	$9.20	$11.70	$6.00	$10.80	$13.80
45-54	$5.60	$10.10	$12.90	$6.80	$12.20	$15.60	$5.60	$10.10	$12.90	$8.00	$14.40	$18.40	$6.80	$12.20	$15.60	$8.00	$14.40	$18.40
55-59	$7.00	$12.60	$16.10	$8.50	$15.30	$19.60	$7.00	$12.60	$16.10	$10.00	$18.00	$23.00	$8.50	$15.30	$19.60	$10.00	$18.00	$23.00
60-64	$10.50	$18.90	$24.20	$12.80	$23.00	$29.30	$10.50	$18.90	$24.20	$15.00	$27.00	$34.50	$12.80	$23.00	$29.30	$15.00	$27.00	$34.50
65+	$14.00	$25.20	$32.20	$17.00	$30.60	$39.10	$14.00	$25.20	$32.20	$20.00	$36.00	$46.00	$17.00	$30.60	$39.10	$20.00	$36.00	$46.00

GET IN THE ZONE

WITH A COMPREHENSIVE HEALTH PLAN THAT IS...

- → SIMPLE TO UNDERSTAND
- → SIMPLE TO APPLY FOR
- → SIMPLE TO USE

Let us show you...

SIMPLE PLAN OPTIONS
Just select the plan that best suits your needs.

NO WAITING PERIOD
Coverage begins the first of the month following approval.

BENEFITS FOR LIFE
If you sign up before you are 75, you have coverage as long as you need it (as long as you pay your monthly premiums, of course).

INCREASING MAXIMUMS
The longer you're on the plan, the better your coverage.

NO PAPERWORK (ALMOST)
Pay-direct card for use at most pharmacies and hospitals, as well as dental, vision and paramedical practitioner offices—virtually no paper claims.

CONVENIENCE WITH MINIMAL OUT-OF-POCKET EXPENSES
Most health service providers can submit your claims online, check eligibility and print statements.

INFORMATION AT YOUR FINGERTIPS

Check your coverage (yes, even for drugs), set up direct deposit, print premium confirmations, find a provider, and more – all online!

TRAVEL COVERAGE INCLUDED

Emergency travel benefits and out-of-country assistance – it's all part of the plan.

LEGAL ASSISTANCE

Legal advice toll-free anywhere in Canada 24/7.

WELLNESS RESOURCE LIBRARY

Online access to an extensive range of health topics.

WIN WIN FOR BUSINESS OWNERS

Premiums may be a tax deductible business expense.

And of course, service with a smile

It just wouldn't be from GSC, if it didn't come with over-the-top customer service – we've got the knowledge to answer your questions, and a personality too!

Even more to feel good about…

As Canada's only national not-for-profit health and dental specialist, with GSC you receive comprehensive coverage while being part of something bigger. We enhance the greater good through charitable giving for initiatives that improve access to better health. And it doesn't hurt that this allows us to offer very competitive rates!

gsc healthassist ZONE