PRIVATE & CONFIDENTIAL
Pre-Existing / Chronic Condition Reporting Form for Excess Medical Insurance

Purpose: To report confidentially any chronic or pre-exisiting conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed under the Excess Medical Insurance Policy. **THIS ONLY APPLIES TO THE EXCESS MEDICAL INSURANCE - YOUR HEALTH SPENDING ACCOUNT STILL ALLOWS YOU TO CLAIM ANY ELIGIBLE EXPENSE FROM DAY ONE.**

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed under the Excess Medical Insurance Policy.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Insurer and the Administrator, MDM Insurance Services Inc., the provider of the Pay-Direct Card.

Name: _____ Employer: _____

Email: _____ Home Tel: _____ Work or Mobile Tel: _____

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

_____ _____

(Signed) (Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
enVia Benefits Program
MDM Insurance Services Inc.
P.O. Box 970
Guelph, ON N1H 6N1

Or FAX this form to: (519) 836-4909