



enVia
BENEFITS PROGRAM

KEY FEATURES:

- Not a traditional insurance plan, rather a tax-effective “private health services plan”
- Much wider range of claimable expenses
- No deductibles, co-payments or waiting periods
- Pay-direct drug & dental claim payment
- No health evidence requirements or pre-existing condition exclusions for Health Spending Account

ELIGIBILITY:

- Incorporated self-employed entrepreneurs
- Sole Proprietors (subject to some CCRA limits)
- Employer Groups, but on an individual basis
- Employees (who work for a “flexible” employer)

Right for you. Right for your employees.

The “enVia Benefits Program” is a new, comprehensive Health and Dental Benefits program designed to freeze your costs and improve your bottom line while offering better, more flexible & useful coverage to you and your staff. And, your costs are tax deductible as a business expense against corporate income!

Available coverage includes:

- a low cost, individual Health Spending Account (eHSA) that lets you claim a much broader range of Health and Dental expenses,
- Catastrophic Insurance - additional protection over and above your eHSA,
- Disability Income Protection - short or long term,
- Accidental Death & Dismemberment Insurance,
- XN Global® Preferred Care - critical illness recovery program,
- Life Insurance,
- Travel Insurance.



What expenses can you claim from an eHSA?

Probably a lot more than you’d think, and definitely a lot more than under any traditional group insurance plan. Here’s just a partial list of eligible expenses (including dependent’s expenses) as defined in the Federal Income Tax Act, and notice how it includes expenses not reimbursed under other medical and dental plans because of deductibles, maximum limits, and co-insurance:

Acupuncture*	Contraceptive Devices**	Insulin & Diabetic Supplies	Oxygen & Equipment	Therapy Equipment
Artificial Limbs	Crowns & Bridgework	Laser Eye Surgery	Physiotherapist	Vein Removal
Athletic Therapy*	Dental Implants	Laser Hair Removal*	Podiatrist	Viagra, Cialis, Levitra
Attendant Care	Dental Treatment	Naturopathic Products**	Prescription Drugs	Vitamins**
Birth Control Pills**	Dentures	Occupational Therapist	Psychologist	Wheelchairs
Chinese Medicine*	Dermatologist Fees*	Optician	Psychotherapy*	X-rays
Chiropractor	Fertility Treatments	Optometrist	Psychiatrist	& more***
Chiropodist	Hair Replacement	Orthodontics	Registered Masseur	
Contact Lenses**	Hydrotherapy**	Orthopedic Shoes	Skin Care	

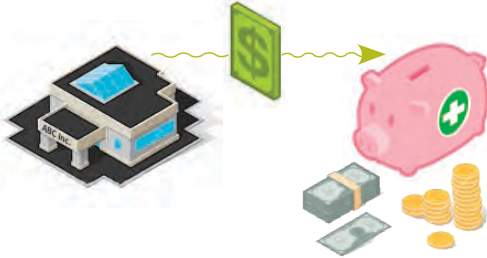
* Must be performed by a licensed medical practitioner;
 ** Must be prescribed by a licensed medical practitioner and dispensed by a licensed pharmacist / medical practitioner as part of their medical services;
 *** As per Section 118.2 (2) of the Federal Income Tax Act and Interpretation Bulletin IT-519R2.

For most people, the enVia Benefits Program represents a new way of covering your Health & Dental Expenses. Please review the following key points to learn how this program is different from a traditional group insurance plan. We're happy to answer any additional questions you may have - please contact us as indicated below if you need more information!

A How the enVia Health Spending Account (eHSA) works:

1 First, the Employer (or you, if self-employed or owner) determines an annual contribution amount per employee ranging from \$1,000 to \$50,000 or more.

2 Next, monthly employer contributions are deposited to individual employee accounts.



Date	Transaction Description	Amount		eHSA Balance
		Debit	Credit	
Jan 1	Initial Employer Contribution		\$125.00	\$125.00
Jan 6	Prescription Drug Claim	\$75.00		\$50.00
Feb 1	Monthly Employer Contribution		\$125.00	\$175.00
Feb 15	Massage Therapy Claim	\$60.00		\$115.00
Mar 1	Monthly Employer Contribution		\$125.00	\$240.00
Mar 12	Eyeglasses Claim	\$300.00		-\$60.00
Apr 1	Monthly Employer Contribution		\$125.00	\$65.00

3 Employee uses funds in eHSA to pay for health & dental expenses. Current balance can be checked online 24/7.



4 Pay-direct Card used to pay for expenses where possible, otherwise employee submits paper receipt for reimbursement.

5 Reimbursement is 100% with no deductible or co-pay. If current balance is less than submitted claim, reimbursement will be made once monthly contributions allow.

B What is Catastrophic Insurance & how does it work?

Your eHSA automatically includes \$25,000 per year (\$1 million lifetime) of Catastrophic Insurance to provide an additional "umbrella of protection" in the event of a sudden serious illness or disease.

When would I use it?

Think of the eHSA as covering your "everyday" or even elective health & dental expenses, and for most people it will be all you ever use. But, if through illness or injury, you suddenly had expenses for expensive prescription drugs or home nursing, for example, then you could use your Catastrophic Insurance to cover the cost.

What does it cover?

Catastrophic Insurance covers Drug, Hospital or Private Duty Nursing (out-of-Hospital) expenses **only**. It does not cover any dental expenses or elective medical expenses.

Are there any limitations?

Yes, there are two limitations or conditions you should be aware of:

First, Catastrophic Insurance only "kicks in" once your claims for Drug, Hospital or Private Duty Nursing have exceeded a deductible of \$2,500 per person per policy year.

Secondly, while no health evidence is required, **there is a 24 month waiting period for pre-existing medications or conditions.**

Note: these limitations apply **only** to the Catastrophic Insurance. **There is no deductible or waiting period for your eHSA claims.**



C What happens to unused eHSA contributions at year end?

Unused contributions from the first plan year are not lost – they carry forward to the second plan year, and if not used by the end of that plan year are forfeited back to the employer.

The one exception to this is for Sole Proprietors, who Revenue Canada rules are not eligible to receive the forfeiture of unused eHSA funds at the end of each second plan year. Instead, Sole Proprietors are limited by the Income Tax Act to deduct \$1,500 for themselves, \$1,500 for their spouse and \$750 / child from their business income as qualifying medical insurance premiums.

Accordingly, **Sole Proprietors with high medical or dental expenses should seriously consider the financial advantages of incorporation**, as there is no limit placed on contributions to a private health services plan. Fortunately, the **enVia Benefits Program offers access to discounted Incorporation Services** should you have need.



D What if I already have benefit coverage through my spouse?

This is quite common, and the eHSA actually works to your advantage when combined with any other group or individual coverage, because **you decide whether you wish claims to be claimed first against your eHSA, or any other insured benefits** that you are also covered by, such as a spouse's program.

This flexibility is very useful, since **you can claim from your eHSA any co-insurance amounts or deductibles** that you must pay out-of-pocket on the spouse's program.

You should also look closely at enVia's Optional Benefits, which may offer additional coverage that's not available in your spouse's program.



The GPS Consulting Group

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905-844-8998 phone | 905-844-2428 fax
www.gpsconsultinggroup.com



enVia eHSA Benefits Program for Atlas Canada Application Form

1 Your General Information

Effective Date of Coverage Requested: _____

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> OTHER _____			
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH	PRIMARY OCCUPATION		ANNUAL EARNINGS	
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE		
HOME TELEPHONE	WORKPLACE TELEPHONE		FAX			
EMAIL ADDRESS			YOUR BUSINESS TYPE OR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SELF-EMPLOYED (INCORPORATED) <input type="checkbox"/> SELF-EMPLOYED (SOLE PROPRIETOR)			
YOUR BUSINESS OPERATING NAME	YOUR BUSINESS ADDRESS		CITY	PROVINCE	POSTAL CODE	
YOUR AGENT / BROKER'S NAME (IF APPLICABLE) The GPS Consulting Group & Insurance Agencies		AGENT / BROKER'S TELEPHONE: 905-844-8998		AGENT / BROKER'S E-MAIL ADDRESS: gord@gpsconsultinggroup.com		
AGENT / BROKER'S ADDRESS: 114 Forsythe Street		CITY Oakville	PROVINCE Ontario	POSTAL CODE L6K 3T3		

2 Your Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 19
Spouse:				
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED

If a Child is over age 19, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
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3 Your enVia Health Spending Account (eHSA) Coverage (includes \$25,000 of Catastrophic Insurance)

1. Please indicate your level of coverage: Single Couple Family

2. Choose your Annual eHSA Contribution Amount:

Note: If you are completing the application as an employee, your contribution amount will have been pre-determined by your employer and the amount communicated to you.

Net Annual Amount Required in eHSA	<input type="checkbox"/> \$1,000 (\$83.33/mo)	<input type="checkbox"/> \$1,500 (\$125.00/mo)	<input type="checkbox"/> \$2,000 (\$166.67/mo)	<input type="checkbox"/> \$3,000 (\$250.00/mo)	<input type="checkbox"/> \$5,000 (\$416.67/mo)	<input type="checkbox"/> \$6,000 (\$500.00/mo)
Monthly Cost*	\$112.00 Single \$124.00 Couple \$130.00 Family	\$162.00 Single \$174.00 Couple \$180.00 Family	\$212.00 Single \$224.00 Couple \$230.00 Family	\$312.00 Single \$324.00 Couple \$330.00 Family	\$512.00 Single \$524.00 Couple \$530.00 Family	\$612.00 Single \$624.00 Couple \$630.00 Family
Net Annual Amount Required in eHSA	<input type="checkbox"/> \$7,200 (\$600.00/mo)	<input type="checkbox"/> \$10,000 (\$833.33/mo)	<input type="checkbox"/> \$12,000 (\$1,000.00/mo)	<input type="checkbox"/> \$15,000 (\$1,250.00/mo)	<input type="checkbox"/> \$25,000 (\$2,083.33/mo)	<input type="checkbox"/> \$50,000 (\$4,166.67/mo)
Monthly Cost*	\$684.00 Single \$696.00 Couple \$702.00 Family	\$945.33 Single \$957.33 Couple \$963.33 Family	\$1,132.00 Single \$1,144.00 Couple \$1,150.00 Family	\$1,412.00 Single \$1,424.00 Couple \$1,430.00 Family	\$2,345.33 Single \$2,357.33 Couple \$2,363.33 Family	\$4,678.67 Single \$4,690.67 Couple \$4,696.67 Family

How much should I contribute this year?

If you are the employer, or self-employed (whether incorporated or a sole proprietor), you choose the annual contribution amount once each year. You should try as best as possible to make a reasonable estimate of anticipated Health & Dental expenses over the coming year. Keep in mind that unused funds from the first year carry over into the second, and if still unused at the end of year two are returned to the employer (except for Sole Proprietors - see Key Concepts for details).

Also bear in mind that if your anticipated expenses for this year are, for example, \$2,000 you could establish that amount as your eHSA for year 1 and then increase it the following year to cover an upcoming large expense such as Orthodontia for a child, or laser eye surgery, for example.

Net Annual Amount Required in eHSA: \$ _____

Monthly Cost (*includes Catastrophic Premium, Administration Fees & Applicable Taxes): \$ _____ / month (a)

4 Choose your Optional Benefits

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. In some cases, a separate application form may be required.

Determine your Occupational Class: Insurers base their rates for some coverage in part on the nature of the work being performed as part of your regular duties. Use the table below to determine your Occupational Class for Life, TTD, PTD and AD&D Coverage. Please contact us if it's not clear what category matches your particular job.

<input type="radio"/> Class 1	All Administrative Office Staff, Office based Managers, Accountants, Sales Staff, IT Staff, Graphic Designers, Real Estate Agents, Lawyers, Retail Sales Staff.
<input type="radio"/> Class 2	All on-site Managers and Superintendents at Mining & similar Operations, Lab Technicians.
<input type="radio"/> Class 3	Nurse, Physiotherapist, Massage Therapist, Personal Support Worker, Nannies, Hospital Cleaning Staff, Light Industrial Workers.
<input type="radio"/> Class 4	All on-site manual workers not exposed to unusual accident risks such as Foreman, Electricians, Finish Carpenters, Plumbers, Cooks, Courier Drivers, Short Haul Truck Drivers, Auto Body Painters, Daycare Worker, Flooring Installers, Cement Layers & Finishers, Painters, and Other Skilled Trades.
<input type="radio"/> Class 5	All on-site heavy manual workers exposed to considerable accident risks, such as Rough Carpenters, Industrial Mechanics, Auto Mechanics, Steamfitters, Farmer, Movers , Restaurant Server, Long Haul Truck Driver , Landscape Workers, and Bricklayers.

a) XN Global® Preferred Care Program: Requires separate Application Form & Health Statement, but please indicate here if you will be purchasing coverage.

b) Temporary Total Disability Benefits (TTD): Following a 30 day waiting period, benefit payable is 66.67% of weekly earnings to a maximum of \$1,500 week.

Occupational Class (from table above)	Rate per \$10 of benefit per month	Monthly Cost per \$500 of weekly benefit	Monthly Cost per \$750 of weekly benefit	Monthly Cost per \$1,000 of weekly benefit	Monthly Cost per \$1,500 of weekly benefit (maximum)
Class 1	\$0.458	\$22.90	\$34.35	\$45.80	\$68.70
Class 2	\$0.488	\$24.40	\$36.60	\$48.80	\$73.20
Class 3	\$0.614	\$30.70	\$46.05	\$61.40	\$92.10
Class 4	\$0.663	\$33.15	\$49.73	\$66.30	\$99.45
Class 5	\$0.780	\$39.00	\$58.50	\$78.00	\$117.00

Weekly Earnings \$ _____ X 66.67% = Weekly Benefit \$ _____ ÷ 10 = _____ X Class Rate per \$10 _____ = **Monthly Cost \$ _____ (b)**
(MAXIMUM \$1,500)

c) Permanent Total Disability Benefits (PTD): Provides a benefit of up to 5X annual earnings after 25 months

Occupational Class (from table above)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000
Class 1	\$0.040	\$2.00	\$10.00	\$20.00
Class 2	\$0.056	\$2.80	\$14.00	\$28.00
Class 3	\$0.079	\$3.95	\$19.75	\$39.50
Class 4	\$0.110	\$5.50	\$27.50	\$55.00
Class 5	\$0.154	\$7.70	\$38.50	\$77.00

Annual Earnings \$ _____ X 5 = PTD Benefit \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$ _____ (c)**
(MAXIMUM \$500,000)

d) Life Insurance: Optional Life Insurance in units of \$10,000 to \$500,000. Coverage terminates at age 65. Please complete attached Personal Health Declaration.

Age Band	Premium rates per \$1,000 per month				
	Class 1	Class 2	Class 3	Class 4	Class 5
18-39	\$0.143	\$0.168	\$0.204	\$0.281	\$0.346
40-44	\$0.270	\$0.295	\$0.331	\$0.408	\$0.473
45-49	\$0.477	\$0.502	\$0.538	\$0.614	\$0.680
50-54	\$0.763	\$0.788	\$0.823	\$0.900	\$0.965
55-59	\$1.085	\$1.110	\$1.146	\$1.223	\$1.288
60-64	\$1.720	\$1.744	\$1.780	\$1.857	\$1.922

Additional Medical Information may be requested by the Insurer for amounts over \$100,000.

rate per \$1,000 per month

Coverage Required: \$ _____ ÷ 1,000 = _____ X _____ = **Monthly Cost \$ _____ (d)**
example: \$100,000 example: 100 example: \$0.295 for age 43 Class 2 example: \$29.50 per month

e) Accidental Death & Dismemberment: No Health Statement required. Available in multiples of \$50,000 to a maximum of \$500,000.

Occupational Class (from table on first page)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000 (maximum benefit)
Class 1	\$0.09	\$4.50	\$22.50	\$45.00
Class 2	\$0.10	\$5.00	\$25.00	\$50.00
Class 3	\$0.12	\$6.00	\$30.00	\$60.00
Class 4	\$0.15	\$7.50	\$37.50	\$75.00
Class 5	\$0.20	\$10.00	\$50.00	\$100.00

Coverage required \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$ _____ (e)**
(MAXIMUM \$500,000)

Life and / or AD&D Beneficiary Designation: (please complete this section ONLY IF APPLYING FOR Life and/or AD&D COVERAGE)

REVOCABLE IRREVOCABLE

BENEFICIARY(IES) SURNAME(S), GIVEN NAME(S) & INITIAL(S) _____

RELATIONSHIP OF BENEFICIARY TO INSURED _____ **If beneficiary is under age of majority, please complete TRUSTEE section**

I, the undersigned applicant, hereby appoint the person(s) stated as my beneficiary(ies) on my current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future.

Applicant's Signature **X** _____ **Date** _____

DECLARATION APPOINTING TRUSTEE (complete if beneficiary is under age of majority)

I do hereby appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority and declare receipt of such Trustee shall be in good discharge to the insurer for the amount so paid. And I hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at _____ **this** _____ **day of** _____ **20** _____

Applicant Signature _____

5 Calculate your Monthly Cost:

1. enVia Health Spending Account (eHSA) Monthly Cost:

Enter amount from line (a) on page 1

\$ _____ (1)

2. Optional Benefits Cost:

Total the amounts from lines (b) through (e) to determine your monthly Optional Benefits cost.

\$ _____ (2)

3. Your Total Monthly Cost:

Total lines 1 and 2 to determine your Total Monthly Benefits Cost. This amount will be withdrawn from your financial institution each month. If you are also applying for XN Global® Preferred Care Insurance (requires a separate application) the monthly premium for that coverage will be added to this total.

\$ _____

Total Monthly Benefits Cost

IMPORTANT: Please attach two cheques - one in the amount of the first month's premium (Total Monthly Benefits Cost above), and one marked "VOID" to enable subsequent monthly automatic withdrawals from your financial institution.

6 Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

I authorize, as appropriate, either my employer to withdraw from my pay OR the Plan Administrator to withdraw from my financial institution, the required insurance premiums / health spending account deposits, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary.

Signed at: _____ this _____ day of _____, _____ Applicant's Signature _____
CITY / TOWN PROVINCE DATE MONTH YEAR

Privacy & Confidentiality We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to the Plan Administrator's Customer Service Dept., the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Mail or Fax your completed application to:

enVia Benefits Program for Atlas Canada
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

This Program is made available through the corporate licence of Maclagan Inc. in Ontario, and Financial Horizons Group provincial licences in all provinces outside of Ontario.

Phone: (416) 446-0115

Fax: (416) 446-7371

E-mail: info@maclagan.ca



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Pre-Existing / Chronic Condition Reporting Form

Purpose: To report confidentially any chronic or pre-existing 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.

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.

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 Administrator, Norfolk Mobility Benefits, Calgary, Alberta and Esorse Corporation, the provider of the enVia Pay-Direct Drug 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
 P.O. Box 47509
 946 Lawrence Ave. East
 Don Mills, ON M3C 3S7

Or FAX this form to: 416-446-7371

If you have any questions or require assistance please contact:
 John Maclagan at: 416-446-0115; email: jmaclagan@sympatico.ca OR Scott Maclagan at: 905-554-0875; email: esmaclagan@rogers.com



Personal Health Declaration

Please complete this Personal Health Declaration accurately and in full. In particular, if you answer "YES" to any of the medical questions below, please provide details on reverse. If you have questions or need further assistance, please call us at (905) 554-0875

Section 1: Applicant Information

APPLICANT NAME	DATE OF BIRTH (DAY / MONTH / YEAR)	APPLICANT'S HEIGHT _____ ft/in or _____ cm	APPLICANT'S WEIGHT _____ lbs or _____ kg
NAME OF APPLICANT'S EMPLOYER	DATE EMPLOYED (DAY / MONTH / YEAR)	CERTIFICATE OR PAYROLL NUMBER (OFFICE USE ONLY)	
OCCUPATION	NORMAL NUMBER OF HOURS WORKED PER WEEK	DIVISION / CLASS (OFFICE USE ONLY)	

Section 2: Health Declaration

Have you ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on reverse.

	APPLICANT
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematous (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you currently taking or have you been prescribed any prescription medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing piloting aircraft, or bungee jumping?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Full name and address of your regular attending physician:

If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. **If the answer is "none", state "none"**

NAME OF APPLICANT'S PHYSICIAN	ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT

For each "YES" answer to any of the questions above, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on the next page.

Section 3: Details for questions answered "YES"

Please provide details for any question answered "YES" on reverse. If additional space is required, please attach a separate sheet.

Question #	Name of Applicant	Illness / Condition	Date of onset	Frequency of episodes	Date of recovery	Medication / Treatment	Daily Dosage	Approximate monthly cost

Section 4: Declaration & Authorization

I understand that, to be eligible for the insurance for which I am applying, I must at all times be covered under my provincial government health plan and be a Canadian resident.

I agree that the statements and answers in this Declaration, on any medical examination and in any written statements or answers furnished as evidence of my insurability shall form the basis of any insurance granted under the terms of the policy issued me. I understand that the Insurers or their service providers reserve the right to verify the answers provided to the questions contained in this Personal Health Declaration at the time of any claim for benefits under the policy issued to me. I declare that all statements and answers recorded in this Declaration are as given by me and are true and complete.

I hereby authorize the Insurer or its service providers, for underwriting and administration of insurance and claims paying purposes only:

- (a) To gather only that information necessary for the objective of the Health & Dental Benefits or Disability Benefits file from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the objective of this file;
- (b) To disclose only the necessary personal information it has relating to me to these same persons and organizations, or as required by law;
- (c) To request a personal investigation report relating to me.

A photocopy of this Authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ 20_____

Applicant's Signature _____

This authorization is valid for the period required to achieve the ends for which it was requested.

MAIL OR FAX TO:

enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave East
Don Mills, ON M3C 3S7

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