

# INSURANCE APPLICATION

Association québécoise des informaticiennes  
et informaticiens indépendants

Policy 95904 - Period from March 1<sup>st</sup>, 2011 to February 29<sup>th</sup>, 2012



1255, University Street, suite 217, Montreal (Quebec) H3B 3B2  
5300, des Galeries Boulevard, suite 415, Quebec (Quebec) G2K 2A2  
Montreal: 514.871.1181 • Quebec: 418.681.7785 • Toll Free: 1.877.371.1181  
info@medicassurance.ca www.medicassurance.ca

## PERSONAL INFORMATION

Name (first and last name)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (day/month/year)
Former name		<input type="checkbox"/> English <input type="checkbox"/> French	Place of birth (province/country)
E-mail		<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutive months.	
Address (residence or office)			
City		Province	Postal Code
Telephone (home)	Telephone (office)	Fax	

## INFORMATION ABOUT YOUR SPOUSE

(Required only if you apply for Couple or Family coverage)

Name (first and last name)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (day/month/year)
Common law spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No		Occupation: _____	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutive months.
Date de cohabitation: _____ (day/month/year)			

## INFORMATION ABOUT YOUR CHILDREN

(Required only if you apply for Single Parent or Family coverage)

Name of the child (first and last name)	Date of birth (day/month/year)	Sex	Student
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No

## LIFE INSURANCE AND ADD

(Included with options 3 and 4)

Amount of insurance offer: \$30,000	Beneficiary designation* <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Beneficiary (name in full)	Relationship to proposed Insured

\*You must check revocable or irrevocable for this application to be considered complete. Where Quebec law applies, a spouse is irrevocable unless you make the designation revocable. If the beneficiary designation is revocable, the applicant can change the beneficiary at any time without the beneficiary's consent. If the beneficiary designation is irrevocable, the beneficiary's written consent is required in order for the applicant to make any change in the beneficiary or the coverage.

## LIFE INSURANCE AND ADD FOR THE DEPENDENTS

(If you choose a Couple, Single Parent or Family coverage, these benefits are included with options 3 and 4)

<b>Spouse:</b> The applicant is automatically the beneficiary for the spouse and dependent child life coverage..	\$5,000	<b>Child (after 24 hours):</b>	\$2,500
---	---------	--------------------------------	---------

## DECLARATION AND AUTHORIZATION

I, DECLARE, that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void. A photocopy version of this declaration is as valid as the original, and shall remain in effect for the duration of my insurance coverage.

Signature of the applicant	Date of the signature (day/month/year)
----------------------------	--

To ensure the confidentiality of the personal information held on you, MédicAssurance Inc. will set up an insurance file in which be entered the information provided on your insurance application, as well as any claim information.

Only those employees or representatives responsible for underwriting, investigating and processing claims or any other person authorized by yourself will have access to this file. Your file will be kept in our offices. You are entitled to consult the personal information contained in this file and to have it rectified, if necessary, by sending a written request to the following address:

- 1255, University Street, suite 217, Montreal (Quebec) H3B 3B2

- 5300, boulevard des Galeries, suite 415, Quebec (Quebec) G2K 2A2

### IMPORTANT:

Your insurance coverage will be effective on the 1<sup>st</sup> of the following month upon receipt of your application duly completed unless you specify otherwise hereunder. The coverage cannot be effective other than the 1<sup>st</sup> of the month.

I wish my coverage be effective on the 1<sup>st</sup> of the month of \_\_\_\_\_ Your initials \_\_\_\_\_

## Direct card

Monthly Premium 9% tax included

### OPTION 1 ■

(Drug with deductible \$100 / \$200 - reimbursement: 75%, Extended Health Benefit – Travel)

AGE	COVERAGE			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
Less than 35	\$47,86	\$100,61	\$75,46	\$162,32
35 - 39	\$47,86	\$100,61	\$75,46	\$162,32
40 - 44	\$66,00	\$138,36	\$103,81	\$225,35
45 - 49	\$66,00	\$138,36	\$103,81	\$225,35
50 - 54	\$66,00	\$138,36	\$103,81	\$225,35
55 - 59	\$96,24	\$197,16	\$128,17	\$236,58
60 - 64	\$144,60	\$284,93	\$185,18	\$284,93
65 - 69	\$375,54	\$746,82	\$647,08	\$746,82

### OPTION 2 ■

(Drug with deductible \$750 / \$750 - reimbursement: 100%, Extended Health Benefit – Travel)

AGE	COVERAGE			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
Less than 35	\$23,49	\$50,09	\$28,23	\$80,80
35 - 39	\$23,49	\$50,09	\$28,23	\$80,80
40 - 44	\$32,41	\$69,05	\$38,93	\$111,44
45 - 49	\$32,41	\$69,05	\$38,93	\$111,44
50 - 54	\$32,41	\$69,05	\$38,93	\$111,44
55 - 59	\$47,25	\$100,68	\$56,83	\$112,50
60 - 64	\$70,96	\$151,26	\$85,37	\$135,49
65 - 69	\$301,92	\$613,15	\$547,27	\$597,39

### OPTION 3 ■

(Life insurance - \$30,000, AD&D, Coverage for your dependents, Drug with deductible \$100 / \$200 - reimbursement: 75%,  
 Extended Health Care - reimbursement: 80%, Extended Health Benefit – Travel)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
Less than 35	\$64,94	\$134,62	\$102,72	\$209,08	\$66,58	\$136,25	\$104,35	\$210,71
35 - 39	\$83,30	\$173,07	\$131,56	\$288,25	\$84,94	\$174,70	\$133,19	\$289,88
40 - 44	\$99,78	\$205,93	\$156,55	\$349,73	\$101,74	\$207,89	\$158,51	\$351,69
45 - 49	\$128,71	\$261,85	\$199,38	\$437,00	\$132,63	\$265,78	\$203,31	\$440,93
50 - 54	\$167,39	\$332,49	\$253,64	\$487,96	\$173,93	\$339,03	\$260,18	\$494,50
55 - 59	\$215,94	\$419,45	\$284,12	\$499,96	\$228,03	\$431,55	\$296,22	\$512,06
60 - 64	\$279,85	\$522,05	\$351,87	\$548,85	\$300,12	\$542,32	\$372,14	\$569,12
65 - 69	\$495,02	\$930,16	\$759,98	\$956,93	\$521,18	\$956,32	\$786,14	\$983,09

### OPTION 4 ■

(Life insurance - \$30,000, AD&D, Coverage for your dependents, Drugs with deductible \$250 / \$500 - reimbursement: 75%,  
 Extended Health Care - reimbursement: 80%, Extended Health Benefit – Travel)

AGE	WOMEN				MEN			
	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
Less than 35	\$44,97	\$92,72	\$71,24	\$142,77	\$46,61	\$94,35	\$72,87	\$144,40
35 - 39	\$57,29	\$118,49	\$90,56	\$195,93	\$58,93	\$120,12	\$92,19	\$197,56
40 - 44	\$68,79	\$141,02	\$107,79	\$237,66	\$70,75	\$142,98	\$109,75	\$239,62
45 - 49	\$89,38	\$179,73	\$137,65	\$297,45	\$93,30	\$183,66	\$141,58	\$301,38
50 - 54	\$116,31	\$228,89	\$175,83	\$333,38	\$122,85	\$235,43	\$182,37	\$339,92
55 - 59	\$152,99	\$290,61	\$199,59	\$344,79	\$165,08	\$302,71	\$211,69	\$356,89
60 - 64	\$198,67	\$362,36	\$247,86	\$380,40	\$218,94	\$382,63	\$268,13	\$400,67
65 - 69	\$413,83	\$770,46	\$655,95	\$788,50	\$439,99	\$796,62	\$682,11	\$814,66

### DENTAL INSURANCE ■ (AVAILABLE ONLY WITH OPTIONS 3 AND 4)

(No deductible – reimbursement: 80%)

#### COVERAGE

Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single parent <input type="checkbox"/>	Family <input type="checkbox"/>
\$64,57	\$128,71	\$96,55	\$153,72

7800-006-en-propo - Rév. 02/2011





# PAYMENT AUTHORIZATION

Association québécoise des informaticiennes  
et informaticiens indépendants

Policy 95904 - Period from March 1<sup>st</sup>, 2011 to February 29<sup>th</sup>, 2012



1255, University Street, suite 217, Montreal (Quebec) H3B 3B2  
5300, des Galeries Boulevard, suite 415, Quebec (Quebec) G2K 2A2  
Montreal: 514.871.1181 • Quebec: 418.681.7785 • Toll Free: 1.877.371.1181  
info@medicassurance.ca www.medicassurance.ca

## PREMIUM PAYMENT METHOD

### Check one box only:

- Monthly Pre-authorized payment:** monthly administration fee of \$1 will be applied to the monthly premium.  
In order to choose this type of payment, please fill in the section: "Pre-authorized payment"
- Payment by credit card:** administration fee of \$1 per transaction will be applied. In order to choose this type of payment, please fill in the section "Credit Card Payment Authorization"  Annual  Half-yearly  Quarterly  Bimonthly  Monthly
- Annual payment by check:**  
Please calculate your premium in prorata according to the annual renewal date of members. The annual renewal date is March 1<sup>st</sup> of each year to February 29<sup>th</sup> of the next year. The check must be payable to MédicAssurance Inc..

## PRE-AUTHORIZED PAYMENT

I hereby authorize MédicAssurance Inc. to withdraw from my account, the details of which appear on the attached specimen cheque, the sum of \$ \_\_\_\_\_ on the 1<sup>st</sup> day of each month and to change the amount to be debited from my account in case of a change in the premiums for which notice has been given 30 days' prior to the date on which the change takes effect.

SIGNATURE OF ACCOUNT HOLDER(S) : \_\_\_\_\_

Date : \_\_\_\_\_ Type of Service: Personal \_\_\_\_\_ Business \_\_\_\_\_

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

### ATTACH A SPECIMEN CHEQUE MARKED "VOID"

(A copy is accepted)

## CREDIT CARD PAYMENT AUTHORIZATION

I authorize, MédicAssurance inc.; to charge my credit card for the amount due according to my insurance certificate; to adjust the amount charged to my credit card should the premiums change if a 30 days notice in writing has been given prior to the adjustment. This authorization can be cancelled at any time with 30 day's written notice.

Visa  Master Card  Amex

CARD NUMBER: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

NAME AS INDICATED ON THE CREDIT CARD: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## THE CONSEQUENCES OF NON-PAYMENT

You are solely responsible for the consequences of a non-payment and any obligations that it may give rise to under the terms and conditions of the policy contract.

You are in default of payment when a pre-authorized payment is not honoured because of non-sufficient funds, closed account or other similar reasons.

If your financial institution does not honour a debit because of non-sufficient funds, MédicAssurance Inc. will debit that amount again with the next monthly debit along with a fee of \$25 after the third return not honoured. MédicAssurance Inc. may also terminate this agreement and the annual premium would then be due for all policies covered by this Agreement.

A notice of "Stop Payment" initiated by you without prior agreement with MédicAssurance Inc. for the payment of the premium, will result in the cancellation of all policies covered by this Agreement.

DOCUMENT TO COMPLETE AND RETURN, ACCOMPANIED  
BY THE DULY COMPLETED APPLICATION.