the co-operators
A Better Place For You®

ContinYou™

APPLICATION FORM

OFFICE USE ONLY
☐ Eligibility confirmed
Effective Date of Coverage ______________ MMM/DD/YYYY
Certificate # ______________

Please complete the information by printing clearly, in ink. In order to avoid delays, please ensure that all required information is provided.

1. GENERAL INFORMATION

Applicant ______________ (First Name) ______ (Initial) ______________ (Last Name)

Address ______________ (Street) ______________ (City) ______________ (Province) ______________ (Postal Code)

Phone Number (_______)______________ Email ______________

Language of Preference: ☐ English ☐ French

Please indicate the current/previous Co-operators Life Insurance Company plan you were covered under:

Group Name ______________

Group # ______________ Certificate # ______________ Date Coverage Ended ______________ MMM/DD/YYYY

2. PLAN CHOICE

*Overage students must complete a Request for Overage Dependent Coverage. Incapacitated overage dependents must complete a Request for Overage Disabled Dependent Coverage prior to reaching the maximum dependent age for consideration of coverage. These forms are available at www.johnstongroup.ca/en/resources.html

I/We apply for ContinYou coverage: ☐ Base ☐ Enhanced ☐ Enhanced Plus

Individuals covered under the above group health and dental plan are eligible for ContinYou coverage.
I/We are applying for coverage for: ☐ Myself ☐ Myself AND my spouse ☐ Myself AND my dependents
☐ Myself AND my spouse AND my dependents

Applicant ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

Spouse ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

Dependent Child* ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

Dependent Child* ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

Dependent Child* ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

Dependent Child* ______________ (First Name) ______________ (Last Name) ____ (Gender) Date of Birth ______________ MMM/DD/YY

3. HEALTH DECLARATION

All questions must be completed.

Though your coverage is guaranteed, you may be eligible for discounted rates. Should you wish to provide evidence of good health, in order to be eligible for discounted rates, complete this Health Declaration Section.

Please check box if any person for whom application is being made (including yourself, spouse and dependents) has been advised, counselled, tested, diagnosed, treated, hospitalized, or recommended for treatment within the last 5 years for the following: (If you answer "YES" to any question, please circle the condition to which you are referring.)

APPLICANT

Physician ______________________ ______ ______________________
First Name Initial Last Name

Address ______________________ ____________ ____________ ____________
Street City Province Postal Code

Date of Last Consultation ______________ Reason ______________________

Height ________ Weight ________

SPOUSE

Physician ______________________ ______ ______________________
First Name Initial Last Name

Address ______________________ ____________ ____________ ____________
Street City Province Postal Code

Date of Last Consultation ______________ Reason ______________________

Height ________ Weight ________

CHILD

Physician ______________________ ______ ______________________
First Name Initial Last Name

Address ______________________ ____________ ____________ ____________
Street City Province Postal Code

Date of Last Consultation ______________ Reason ______________________

Height ________ Weight ________

	Applicant	Spouse	Child
1. Do you or any of your dependents have any physical defect or infirmity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you or any of your dependents suffered from any recurring illness or injury, whether or not medical attention was sought?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Details to Health History (Give details on each item checked "Yes" above)

Question Number	Person Affected	Condition/Diagnosis	Treatment (surgeries/medications)	Treatment Dates From/To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/ Institution

4. PAYMENT

To ensure we accurately encode all the necessary information, please enclose a sample cheque marked "Void – Premium Payment."

I hereby tender an initial premium of $ ____________ payable to Johnston Group Inc. which represents the premium amount for one month of coverage based on my age, province of residence, and dependents to be covered under this plan. I hereby authorize Johnston Group Inc. through Toronto-Dominion Bank to make automatic deductions from the account below on the 1st day of each month.

Bank ____

Address ______________________ ______________ ______________ ______________
Street City Province Postal Code

5. REQUEST FOR DIRECT DEPOSIT OF EXTENDED HEALTH AND DENTAL CLAIMS

To ensure we accurately encode all the necessary information, please enclose a sample cheque marked "Void – Direct Deposit."

I hereby authorize Johnston Group Inc. to make a direct deposit of my benefit payment(s) to:

☐ the same chequing account shown on attached 'Void' cheque, or
☐ to a different chequing account indicated below:

Bank ____

Address ______________________ ______________ ______________ ______________
Street City Province Postal Code

6. DECLARATION AND AUTHORIZATION

I/We hereby apply for Group Benefit Conversion Coverage. I/We certify that the information provided herein is true, accurate and complete; and that I am or have been covered under a group health and dental plan indicated above within the last 60 days. I understand that I and my dependents must currently be covered under my Provincial Health plan and remain covered in order to be eligible for coverage. I/We agree that any coverage issued in consequence of this application shall not become effective until the application is approved.

I authorize The Co-operators, Johnston Group Inc., their advisors and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents, including health professionals, institutions, insurers and reinsurers. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. A photocopy of this authorization is as valid as the original and shall remain in effect throughout the duration of my coverage under this benefit plan.

Applicant Signature ______________________________ Date ______________
MMM/DD/YYYY

Spouse's Signature (if applying)______________________________ Date ______________
MMM/DD/YYYY

Please return the completed application and first month's premium to:

ContinYou
National Service Centre
1051 King Edward St.
Winnipeg, MB R3H 0R4

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