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The McLennan Group Home Care Assistance

UV INSURANCE

UV Insurance is a trade name and trademark of The Union Life Mutual Insurance Company
C.P. 696, Drummondville, QC, J2B 6W9 | Phone 819 478-1315 Toll free 1-800 567-0988 Fax 819 474-1990

CLEAR FORM

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APPLICATION

☐ New enrolment Contract No.:

For agent use	Advisor information	Code	%
MGA (if applicable)	Name of advisor (administrator)		
	Name of advisor (2)		

1. INSURED INFORMATION

First Name: Last Name:

Date of Birth:_____/_____/_____ (D D / M M / Y Y Y Y) Gender: ☐ M ☐ F Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone:
Home Office Cell

E-mail: Carp Member Number:

2. OWNER (IF DIFFERENT FROM THE INSURED)

First Name: Last Name:

Date of Birth:_____/_____/_____ (D D / M M / Y Y Y Y) Gender: ☐ M ☐ F Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone:
Home Office Cell

E-mail:

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3. CHOICE OF COVERAGE

		Premium
HomeCare Assistance	Focused Home Care ☐ $75,000 ☐ $125,000	
	Core Home Care combined with Health Plan ☐ $50,000 ☐ $100,000	
	Policy fee	
	Total annual premium	
	Monthly premium = Annual premium x 0.09	

If a couple subscribes to Home Care Assistance at the same time and are both approved, a discount of 10% is applicable for the insured and the following spouse:

Name	Relationship

4. BANKING INFORMATION

Please attach a blank cheque marked "VOID" with the application

Name of Financial Institution:

Address of Financial Institution:

Insert the numbers found on the bottom of the cheque, as shown in the following example:

Branch Number:	Financial Institution Number (Bank):	Account Number:

5. PREMIUMS AND METHOD OF PAYMENT

☐ **Monthly Pre-authorized debit $**_____(See section 6)

Desired withdrawal date: the_____day of each month (except 29th,30th, and 31st)

☐ **Annual Pre-authorized debit $**_____(See section 6)

The initial withdrawal date will be the same as the date of issue of the contract. Afterwards, the withdrawal date will be the same as the renewal date.

☐ **Annual $** _____

Amount paid with application **$**_____

Make cheque payable to Odyssee Insurance in Trust.
Odyssee Insurance is the third party administrator on behalf of UV Insurance.

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6. PRE AUTHORISED DEBIT (PAD) AGREEMENT

Only fill out for a NEW insurance POLICY, if PAD was chosen in the application.

Banking Information	Please attach a blank cheque marked « **VOID»**.
Type of Service (check the appropriate box)	☐ **PERSONAL** — If debit is from a personal account ☐ **BUSINESS** — If debit is from a corporate account
Withdrawal Arrangements This pre-authorised agreement is considered a variable one.	1. I authorize the insurer or his representative to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. **2.** If a pre-authorised debit is returned due to insufficient funds (NSF) in the account, the insurer or his authorized representative, will withdraw the related $25 fee from the same account, without notice. 3. I agree to the debiting of my account on the regular pre-authorised debit (PAD) withdrawal day as indicated on the application or the next business day (Subject to change). 4. If all preconditions for the **conditional temporary insurance agreement are met**, I accept that my bank account be debited for the first PAD as of the date of signing of the application. Please check the box if you refuse. ☐
Waiver	**I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.***
Cancellation	You may cancel this pre-authorized debit agreement at any time, subject to providing the insurer or its authorized representative with 10 days' written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca.)
Method of Payment	Any cancellation of this pre-authorized debit agreement will not affect the agreement between you and the insurer whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit www.cdnpay.ca.
Exclusive Rights	All amounts transferred from the pre-authorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance contract.

*The insurer or its authorized representative will not increase your pre-authorized debit or change your debit date after your insurance contract becomes effective without notifying you.

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7. NAME, SIGNATURE AND TITLE OF PAYERS (ACCOUNT OWNERS) FOR « PAD»

Only fill out if different from the proposed insureds or owners named in sections 6 and 7

If two signatures are required to sign on the account, both account owners must sign this Authorization.

If the **Account Owner** is a **legal entity** (corporation, association, etc.), the signature of the authorized individuals with their **title is required.**

PRE-AUTHORIZED DEBIT AGREEMENT: In the event that this declaration is for the addition of a contract rider or of a contract instead of a rider on an existing contract simply because the agent is not the agent (administrator) on the existing contract, you hereby acknowledge and agree that the banking information on file for the existing contract will be used for the rider or contract referred to in this declaration, including the withdrawal date. In the case of a contract instead of a rider on an existing contract simply because the agent is not the agent (administrator) on the existing contract, you also agree to the withdrawal of the first premium from the date of issue of the existing contract to which this declaration applies. Subsequent premiums will be withdrawn on the same date as the existing contract's premiums.

Name: _____

Title: _____

Signature: X _____ Date: _____

Name: _____

Title: _____

Signature: X _____ Date: _____

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8. INSURABILITY DECLARATION

A - In the past five (5) years, the insured hereby declares that he or she:

1) Has not been hospitalized due to a suicide attempt, depression, anxiety, chronic fatigue or any other emotional disorder.

B - The insured declares that he or she has never had any of the following conditions:

1) Acquired immunodeficiency syndrome (AIDS), or affection connected to AIDS (ARC) or any immunodeficiency disorder or undergone a test indicating the presence of the AIDS virus or antibody to the AIDS virus.
2) Heart failure, cardiomyopathy.
3) Currently being treated for cancer, have been diagnosed with metastatic cancer, have had two (2) or more cancers in the past (other than the basal cell carcinoma) including cancer reccurence.
4) Stroke, paralysis or two (2) or more transient ischemic attacks (TIA).
5) Liver cirrhosis, chronic hepatitis B, hepatitis C.
6) Insulin-dependent diabetes.
7) Chronic renal disease, been on dialysis, have undergone or are waiting for an organ transplant.
8) Amputation as a result of illness.
9) Ataxia, transverse myelitis, myasthenia gravis or post-polio syndrome.
10) Cystic fibrosis, pulmonary fibrosis, chronic respiratory disease requiring the use of oxygen.
11) Motor neurone disease, amyotrophic lateral sclerosis, primary lateral sclerosis, Kennedy syndrome, multiple sclerosis, Parkinson's disease, Huntington's Chorea.
12) Memory loss, dementia, Alzheimer disease.
13) Bladder or bowel incontinence requiring regular use of incontinence supplies.
14) Dizziness, vertigo, loss of consciousness or numbness for which no diagnosis has been made.
15) Osteoporosis with fractures or systemic lupus erythematosus.
16) Been treated or have been advised to reduce the use of alcohol or drugs due to dependency.
17) Awaiting an investigation or a scheduled surgery that has not yet been completed.

C - The insured also declares that he or she is not receiving at this time or has not been advised to receive:

1) Care in a hospital, psychiatric, convalescence home and rehabilitation centre.
2) Physiotherapy at home or requires the assistance of medical accessories such as: cane, walker, wheelchair.
3) Assistance with two or more of the daily living activities such as bathing, eating, dressing, walking, taking medication, toileting, or using the toilet.

Signed at _____ , this _____ day of _____ , 20_____.
(Province)

Signature : _____
Signature of the proposed insured

Signature : _____
Signature of the advisor or witness

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9. DECLARATIONS, AUTHORIZATIONS AND SIGNATURES

- I confirm that each eligible proposed insured holds a valid card from his/her provincial health government plan.
- I confirm that the information and answers that I have provided in this document are true.
- I confirm that the information and answers that I have provided are true and complete and acknowledge that they constitute the basis of my insurance coverage.
- I understand that if any answer is false or incomplete, any insurance coverage granted may be voided.
- I understand that I may be refused for insurance coverage if, in the opinion of the insurer, I am not insurable for the insurance coverage.
- I understand that any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date insurer makes a decision must be reported to the insurer.
- I understand that if I fail to do so, any insurance coverage granted may be voided.
- I authorize any doctor, health professional or institution according to the health and social services legislation, insurance companies, or any other agency, institution or person in possession of information about me or my health to transmit it to the insurer and its reinsurers.
- In the event of a claim, I authorize any police force and any other agency that holds information regarding my claim to communicate such information to the insurer and its reinsurers.
- I have retained a copy of this document.
- I acknowledge having been notified that the financial advisor is to be paid by commission in relation to the transactions described in this insurance application. I have been inform the he/she is independant of the insurer and is not its representative.
- I authorize the insurer to deposit all my claim reimbursements to the designated bank account.
- I acknowledge receipt of the **Authorization to obtain and release personal information to a third party** and the **Agreement for the establishment of a personal file.**
- This authorization is valid for the purposes of this contract, its modification, or its reinstatement.
- I acknowledge that a reproduction of this authorization shall be as valid as the original.
- I authorize the insurer or Odyssey Insurance (Groupe Financier Odyssée Inc) to use my personal information in order to send me information on other products and services that might interest me. If no, please check (√) the following:

  ☐ I do not authorize this use.

Signed at_____, this _____ day of_____ , 20_____.
(Province)

Signature :_____ Signature : _____
Signature of the proposed insured Signature of the advisor

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AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

NOTICE : This authorization applies to the insured, their spouse, as well as any dependents who are the subject of the insurance application.

In order to assess insurability, maintain your file and claims assessment, any individual or legal entity holding personal information about you including any health information, medical history or eligibility for claims, are authorized to transmit such information to the insurer, its agents or its reinsurers upon request. This includes physicians or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, personal information agencies, financial advisors, any financial institutions, the owner, your employer or previous employer, the CNESST or other Workmen's Compensation Board, Canada or Quebec Pension Plan, the SAAQ or other Department of Motor Vehicles, the RAMQ or other provincial Health Departments, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Furthermore, the insurer or its agents are authorized to transmit the information to such third parties as well as its reinsurers. For the same purpose and to gather the same type of information, the insurer, its agents or its reinsurers may request an investigative report about you and to use information in their possession in other files.

This consent may also be used for a request for additional insurance or a contract modification.

AGREEMENT FOR THE ESTABLISHMENT OF A PERSONAL FILE

The insurer may retain the services of a specialized administrator to manage your insurance file as well as your claims. To ensure the confidentiality of your personal information, the insurer will establish a file in which such personal information will be held, and whose purpose is to allow you to benefit from an insurance coverage and additional financial services the company offers. Only authorized employees of the insurer or specialized administrator will have access to this file.

In the case of an insurance contract including your spouse or dependents, please notify the persons concerned that documents containing personal information will be sent directly to you.

To do so, a written request must be sent to the Officer in charge of the access to information at the following address:

UV INSURANCE
C.P. 696, Drummondville, QUEBEC, J2B 6W9
Phone: 819 478-1315
Toll free: 1-800 567-0988
Fax 819 474-1990

Give this copy to the proposed insured