

Return to:
 PDAdmin Group
 200 - 211 Consumers Road
 Willowdale, ON M2J 4G8

Application Form
Questions? Call 1-800-565-4066 for Assistance

Part 1 - Personal Information

| | | | | |
|--------------|---|-------------|----------------------------|---|
| Last Name | First Name | Initial | Gender M F | Corporate ID #4821 |
| Address | | Apt. # | Date of Birth (DD/MM/YYYY) | |
| City | Province | Postal Code | Language English French | |
| Phone () | Business Phone () | Ext. | Fax () | Covered by Provincial Health Care Yes No |
| Email | Check here if you would like to receive your policy documents by e-mail instead of paper. | | | |

For couple or family coverage, please complete the following information about your dependants:

| Full Name | Gender | Date of Birth (DD/MM/YYYY) | Covered by Provincial Health Care | |
|-----------|--------|-------------------------------|-----------------------------------|----|
| Spouse | M F | | Yes | No |
| Dependant | M F | | Yes | No |
| Dependant | M F | | Yes | No |
| Dependant | M F | | Yes | No |

Part 2 - Plan Type, Coverage Category

| | | |
|---|---|---|
| Please select the desired plan type: | Please select the optional benefits desired: | |
| Advantage Plan Comprehensive Plan with Drug Card Comprehensive Plan without Drug Card | Hospital Cash Emergency Travel Medical (Available only prior to age 70) | Major Dental AD&D - Number of Units (10 Max) _____ (Available only prior to age 71) Enhanced Prescription Drugs \$2,500 Deductible _____ \$5,000 Deductible _____ Please note that medical underwriting is required. Contact us at 1-800-565-4066 for a medical underwriting form. |
| Please select the coverage category desired: Single Couple Family | | |

Part 3 - Prior Coverage

Please provide us with the following information regarding your previous coverage

| | |
|-------------------|---------------------------------|
| Company Name | Dates Benefits End (DD/MM/YYYY) |
| Insurance Company | Policy Number |
| | Certificate/ID Number |

Part 4 - Premium Calculation

Those with previous coverage within the last 60 days please use the Preferred Plus rate.
 Those with no previous coverage within the last 60 days please use the Standard rate.
 * Pre-existing conditions are covered under this plan.

| | | | | |
|---------------------------------|-------------------------------|----------|----------------------------------|---|
| <u>Health Plan Premium</u> | Preferred Plus | Standard | Monthly Premium | = |
| <u>Optional Benefit Premium</u> | Hospital Cash | | Monthly Premium | = |
| | Major Dental Option | | Monthly Premium | = |
| | Emergency Travel Medical | | Monthly Premium | = |
| | AD&D | | Monthly Premium | = |
| | Enhanced Drug Monthly Premium | | Monthly Premium | = |
| | | | Total Monthly Premium | = |
| Initial Payment ➤ | | | Total Monthly Premium X 2 | = |

