ENROLMENT APPLICATION
EXTENDED HEALTH CARE & DENTAL PLANS

If you have any questions about the plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Inc. at 1-877-989-2600 or via email at pbservicewest@johnson.ca

1. PLEASE PRINT CLEARLY – APPLICATION INFORMATION:

First Name(s)	Last Name	Sex
		☐ Male ☐ Female

Address (Including Apartment/Unit Number)

City/Town	Province/Territory	Postal Code	Telephone Number
			( ) –

Date of Birth (Day / Month / Year)	Provincial Health Number	E-mail Address
D M Y		

2. PLAN SELECTION:

EXTENDED HEALTH CARE (EHC) PLAN WITH "PRESTIGE" EMERGENCY TRAVEL (Includes Trip Cancellation):

I wish to enrol in the EHC Plan with Emergency Travel *:

☐ **No**
☐ **Basic**
☐ **Enhanced**

* Emergency Travel coverage is a mandatory component of the Extended Health Care (EHC) Plan.

Are you enrolled in your Province's Pharmacare Plan? ☐ **Yes** ☐ **No**

Applicable to Provinces / Territories where a Pharmacare Program exists.

If no, please contact your province's Pharmacare to enrol in their program as it is a requirement for the Probus Plan.

Indicate status of coverage required:

☐ **Single** ☐ **Couple** ☐ **Family**

Termination Date of Your or Your Spouse's Group EHC Plan:

Day	Month	Year
D	M	Y

DENTAL PLAN:

I wish to enrol in the Dental Plan:

☐ **No**
☐ **Basic** (80% Basic/Preventative; 80% Minor Restorative)
☐ **Enhanced** (80% Basic/Preventative; 80% Minor Restorative; 50% Major Restorative)

Indicate status of coverage required:

☐ **Single** ☐ **Couple** ☐ **Family**

Termination Date of Your or Your Spouse's Group Dental Plan:

Day	Month	Year
D	M	Y

Note: *Once you enrol in the Enhanced EHC or Dental Plan, you must remain in the plan for 24 months.*

3. IF YOU HAVE SELECTED COUPLE OR FAMILY COVERAGE, PLEASE PROVIDE SPOUSAL/DEPENDENT DETAILS:

First Name(s)	Last Name	Sex
		☐ Male ☐ Female

Provincial Health Number	Date of Birth (Day / Month / Year)	Dependents age 21+
	D M Y	☐ Full Time Student ☐ Disabled

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

SPOUSAL/DEPENDENT DETAILS (CONTINUED):

First Name(s)	Last Name	Sex
		☐ Male ☐ Female

Provincial Health Number	Date of Birth (Day / Month / Year)			Dependents age 21+
	D	M	Y	☐ Full Time Student ☐ Disabled

4. I HEREBY CERTIFY THAT I AM A MEMBER IN GOOD STANDING OF PROBUS CENTRE - CANADA INC. AND MY ELIGIBILITY CEASES UPON TERMINATION OF MY PROBUS MEMBERSHIP:

I authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non Sufficient Funds (NSF) notices on my account.

I recognize that the Probus EHC Plans require members to be enrolled in their provincial Pharmacare Program. If you are not already enrolled in your province's Pharmacare Program, please contact Pharmacare as soon as possible.

I understand Dental coverage will begin on the day Johnson Inc. receives my completed application or on the date prior group coverage terminates if applying during the 60 day eligibility period. I understand EHC coverage will become effective on the later of the date prior group coverage terminates if applying during the 60 day eligibility period, or the date the completed application is approved by the insurer applying as a late entrant.

I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is September 1.

PRIVACY CONSENTS:

I authorize my "Group" Probus Centre – Canada Inc., my "Plan Administrator" Johnson Inc., my "Insurer" Desjardins Financial Security and my "Administrator" Sigma Assistel (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application, (the "Information") for the purposes of the Extended Health Care and/or Dental Plans (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with Information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Group, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial health number and any Group member ID for the purposes of identification and administration.

DEDUCTION SOURCE:

☑ **Automatic Bank Withdrawal**. I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the plan administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5th deduction pays for September coverage.

X _____ _____

Signature of Applicant **Date**

X _____ _____

Signature of Spouse (If couple or family coverage selected) **Date**

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC.
PLAN BENEFITS SERVICE
11120 – 178 Street
Edmonton, Alberta T5S 1P2

JOHNSON

Please direct all inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation to the Plan Administrator, Johnson Inc. at 1-877-989-2600 or pbservicewest@johnson.ca.