You must save the file on your hard drive prior to filling the form electronically.

INSURANCE APPLICATION

médicassurance

2197 Sherbrooke Street East, suite 200, Montréal (Québec) H2K 1C8
CP 47115 CSP Sheppard, Québec (Québec) G1S 4X1
Montréal: 514 871-1181 | Québec: 418 681-7785 | Toll-Free: 1 877 371-1181
Fax | Montréal: 514 871-4943 | Toll-Free: 1 877 871-4943
info@medicassurance.ca | www.medicassurance.ca

Young Bar of Montreal

Policy 32385 - Period from August 1, 2018 to July 31, 2019

INFORMATION ABOUT YOU

Last name ○ Woman ○ Man	Date of birth (day / month / year)
First name ○ English ○ French	Place of birth (province / country)
E-mail address	○ Smoker ○ Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutives months
Address ○ Residence ○ Office	City
Province	Postal code
Telephone (residence) / Telephone (office)	Telephone (mobile)
Month and year of the taking of the oath	Regional Bar

INFORMATION ABOUT YOUR SPOUSE

Required only if you apply for Couple or Family coverage

Name (Last name, First name) ○ Woman ○ Man	Date of birth (day / month / year)
Common law spouse: ○ Yes ○ No Occupation: _____ Date of cohabitation (day / month / year): _____	○ Smoker ○ Non-smoker Non-smoker means that you have not used any tobacco products or tobacco cessation products within the last 12 consecutives months.

INFORMATION ABOUT YOUR CHILDREN

Required only if you apply for Single Parent or Family coverage

Name of the child (Last name, First name)	Date of birth (day / month / year)	Sex	Student
		○ Female ○ Male	○ Yes ○ No
		○ Female ○ Male	○ Yes ○ No
		○ Female ○ Male	○ Yes ○ No
		○ Female ○ Male	○ Yes ○ No

DECLARATION AND AUTHORIZATION

I, the undersigned, 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 (electronic signatures are not accepted)	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 one of the following addresses:

- 2197 Sherbrooke Street East, suite 200, Montréal (Québec) H2K 1C8 - CP 47115 CSP Sheppard, Québec (Québec) G1S 4X1

IMPORTANT: Your insurance coverage will be effective on the 1st of the following month upon receipt of your application duly completed unless you specify otherwise hereunder. The coverage cannot be effective other than the 1st of the month and will be canceled on the last day of the month following receipt of 30 days written notice from you.

I wish my coverage be effective on the 1st of the month of _____. Your initials _____

You must save the file on your hard drive prior to filling the form electronically.

MEDICAL FORM

Young Bar of Montreal
Policy 32385

médicassurance
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Required only if you apply for enhanced coverage (1, 2, 3, 4, 5 and 6)

APPLICANT'S NAME

Last name	First name

1 | During the last six (6) months, have you or your dependents received a diagnosis or treatment and/or been prescribed medication for one of the following conditions:	YES	NO
a) Cerebrovascular or neurological disorder	○	○
b) Heart, circulatory, vascular disorder including aneurysm	○	○
c) Emotional, psychological or nervous disorder	○	○
d) Immunological disorder, including HIV infection or AIDS	○	○
e) Respiratory or pulmonary disorder (excluding cancer)	○	○
f) Stomach, intestinal, kidney , bladder, pancreatic or liver disorder, including hepatitis B and C	○	○
g) Rheumatoid arthritis, ankylosing arthritis or any other form of arthritis	○	○
h) Cancer	○	○
i) Diabete	○	○
j) Have you ever consulted a health professional for any physical or mental disorders?	○	○

For each question answered in the affirmative, please specify the question no. and the person's name and provide details about the disorder, symptoms, duration, treatments, start date of the disorder and date of recovery.

2 | Are you or any of your dependents now taking or do you have in your possession a prescription for one or more medications other than those mentioned above, if any? If so, please specify the name of the person and the medications involved.	YES	NO
	○	○

DECLARATION AND AUTHORIZATION

I declare that the answers and statements made in this application are, to my knowledge, complete and truthful. I recognize that the insurance requested is governed by the terms of the group prescription drug insurance policy. I understand that any intentional omission or false statement can cancel my insurance. This consent is valid for the purposes of this contract, its modification, extension or reactivation. Moreover, I authorize any physician, hospital, insurance company, other health professional, MédicAssurance and Assomption Vie to exchange information concerning this request for the purposes of processing the application and the administration of my health insurance plan. I assume responsibility for any expenses incurred for completing this form. A copy of this authorization will be as valid as the original.

Signature of the applicant (electronic signatures are not accepted)	Date of the signature (day / month / year)

Direct card
Monthly premium 9% tax excluded

BASIC OPTION

Generic drugs mandatory - Deductible is equivalent to the maximum annual contribution established by the RAMQ*
*Adjusted on July 1 of each year – reimbursement 100%

AGE	COVERAGE			
	Single	Couple	Single parent	Family
	$100.32	$201.96	$150.48	$252.12

OPTION 1

Generic drugs mandatory - reimbursement: generic 100% and brand-name 70%, deductible $200/$300, **Critical illness** - $10,000

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$110.00	$195.95	$150.38	$236.34
25 - 29	$110.00	$195.95	$157.70	$243.43
30 - 34	$110.00	$195.95	$157.70	$243.43
35 - 39	$115.62	$206.60	$166.27	$257.27
40 - 44	$120.29	$216.10	$173.29	$269.10
45 - 49	$145.92	$271.91	$212.87	$338.88
50 - 54	$176.02	$334.53	$258.62	$417.13
55 - 59	$184.16	$356.60	$272.26	$444.70
60 - 64	$209.79	$402.47	$309.35	$502.03

OPTION 2

Generic drugs mandatory - reimbursement: generic 100% and brand-name 70%
Medical expenses – reimbursement 80%, deductible $200/$300 applicable to drugs and medical expenses,
Critical illness - $10,000, **Travel and trip cancellation insurance**

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$126.28	$230.58	$182.93	$287.21
25 - 29	$144.76	$255.17	$204.73	$317.36
30 - 34	$145.41	$255.17	$204.73	$317.36
35 - 39	$151.32	$269.85	$217.92	$336.16
40 - 44	$164.91	$291.67	$237.04	$363.37
45 - 49	$193.40	$346.45	$279.21	$431.84
50 - 54	$225.79	$418.58	$329.58	$522.00
55 - 59	$258.42	$474.63	$376.28	$591.95
60 - 64	$299.77	$545.87	$435.38	$680.95

OPTION 3

Generic drugs mandatory - reimbursement: generic 100% and brand-name 70%
Medical expenses – reimbursement 80%, deductible $200/$300 applicable to drugs and medical expenses,
Critical illness - $10,000, **Travel and trip cancellation insurance, Dental care** reimbursement: 80%

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$165.83	$309.69	$255.72	$384.25
25 - 29	$184.32	$334.27	$277.52	$414.40
30 - 34	$184.97	$334.27	$277.52	$414.40
35 - 39	$190.88	$348.95	$290.70	$433.20
40 - 44	$204.47	$370.78	$309.82	$460.41
45 - 49	$232.96	$425.56	$351.99	$528.88
50 - 54	$265.35	$497.69	$402.36	$619.04
55 - 59	$297.97	$553.73	$449.06	$688.99
60 - 64	$339.33	$624.97	$508.16	$777.98

OPTION 4

Generic drugs mandatory - reimbursement: 100%, deductible $900, **Critical illness** - $10,000

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$48.47	$90.70	$70.26	$112.49
25 - 29	$48.77	$91.55	$70.79	$113.56
30 - 34	$50.44	$93.06	$72.82	$115.45
35 - 39	$54.20	$103.98	$79.32	$129.10
40 - 44	$56.69	$105.04	$82.06	$130.41
45 - 49	$57.63	$108.96	$83.99	$135.30
50 - 54	$74.94	$142.60	$109.42	$177.08
55 - 59	$76.46	$144.52	$111.42	$179.47
60 - 64	$82.80	$154.23	$120.14	$191.59

OPTION 5

Generic drugs mandatory - reimbursement: 100%
Medical expenses - reimbursement 80%, deductible $900 applicable to drugs and medical expenses,
Critical illness - $10,000, **Travel and trip cancellation insurance**

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$75.31	$133.55	$107.77	$166.11
25 - 29	$87.64	$157.34	$126.01	$195.83
30 - 34	$90.87	$165.13	$131.21	$205.58
35 - 39	$94.08	$168.51	$135.09	$209.67
40 - 44	$111.71	$199.78	$160.79	$248.75
45 - 49	$140.42	$254.88	$203.28	$317.61
50 - 54	$203.31	$389.73	$299.09	$485.29
55 - 59	$252.74	$476.33	$369.99	$593.34
60 - 64	$300.37	$560.61	$438.45	$698.46

OPTION 6

Generic drugs mandatory - reimbursement: 100%
Medical expenses - reimbursement 80%, deductible $900 applicable to drugs and medical expenses,
Critical illness - $10,000, **Travel and trip cancellation insurance, Dental care** reimbursement: 80%

AGE	COVERAGE			
	Single	Couple	Single parent	Family
18 - 24	$111.47	$205.87	$174.29	$254.82
25 - 29	$123.80	$229.65	$192.55	$284.53
30 - 34	$127.03	$237.44	$197.74	$294.29
35 - 39	$130.24	$240.82	$201.63	$298.37
40 - 44	$147.87	$272.10	$227.32	$337.46
45 - 49	$176.58	$327.21	$269.81	$406.31
50 - 54	$239.47	$462.04	$365.62	$574.00
55 - 59	$288.92	$548.65	$436.51	$682.04
60 - 64	$336.53	$632.92	$504.99	$787.16

PAYMENT AUTHORIZATION

Young Bar of Montreal

Policy 32385 - Period from August 1, 2018 to July 31, 2019

médicassurance

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PREMIUM PAYMENT METHOD

I wish to use the following means of payment:

☐ **Preauthorized bank payments:** administration fee of $2 per transaction, except for an annual payment.
Please complete the "Preauthorized Bank Payment Authorization" section. ◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Bimonthly ◯ Monthly

☐ **Credit card:** administration fee of 2% of the premium.
Please complete the "Credit Card Payment Authorization" section. ◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Bimonthly ◯ Monthly

☐ **Annual cheque:** Please calculate your premiums pro-rated (amount of the monthly premium x number of months covered) to reflect the annual renewal date of the policy. The period covered is indicated below. Your cheque should be made 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 1st 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): _____ _____
(electronic signatures are not accepted)

DATE (day / month / year): _____ 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 (Pre-Authorized Debit) Agreement, I may contact my financial institution or visit **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**.

ATTACH A SPECIMEN CHEQUE MARKED "VOID"
Copy is accepted

CREDIT CARD PAYMENT AUTHORIZATION

I hereby authorize MédicAssurance inc. (plan administrator) to charge my credit card for the amount due according to my insurance certificate and 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 days written notice.

◯ Visa ◯ MasterCard ◯ American Express

CARD NUMBER: _____ EXPIRATION DATE (day / month / year): _____

CARDHOLDER NAME (as indicated on the card): _____

SIGNATURE: _____ DATE (day / month / year): _____
(electronic signatures are not accepted)

THE CONSEQUENCES OF NON-PAYMENT

You are responsible for the consequences if you fail to make a payment provided in the insurance contract, i.e. when a payment is not made for any reason. At MédicAssurance inc., we know that mistakes can happen and that is why we do not charge any additional fees the first time this situation occurs. However, the second time, a fee of $45 will be charged, each time a pre-authorized payment is not honoured by your financial institution. MédicAssurance inc. will then withdraw the unpaid amount at the same time as the pre-authorized payment for the following month. Moreover, MédicAssurance inc. may terminate the pre-authorized payment method, making the annual premium then payable in full for any insurance contract the pre-authorized payment had been arranged for. A stop payment for any pre-authorized payment on the payment of your monthly premium without any prior arrangement or agreement with MédicAssurance inc. could result in cancellation of the insurance contract for which the preauthorized payment was intended.

DOCUMENT TO BE COMPLETED AND RETURNED, ACCOMPANIED BY THE APPLICATION DULY COMPLETED.