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

AUTORISATION DE PAIEMENT

Jeune Barreau de Montréal

Police 32385 - Période du 1er mai 2018 au 31 juillet 2019

médicassurance

2197, rue Sherbrooke Est, bureau 200, Montréal (Québec) H2K 1C8
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MODE DE PAIEMENT DES PRIMES

Je désire me prévaloir du mode de paiement suivant :

☐ **Prélèvements bancaires préautorisés :** frais administratifs de 2 $ par transaction, à l'exception du paiement annuel.
Veuillez remplir la section « Autorisation de prélèvements bancaires ». ◯ Annuel ◯ Semestriel ◯ Trimestriel ◯ Bimestriel ◯ Mensuel

☐ **Carte de crédit :** frais administratifs de 2 % de la prime.
Veuillez remplir la section « Autorisation de paiement par carte de crédit ». ◯ Annuel ◯ Semestriel ◯ Trimestriel ◯ Bimestriel ◯ Mensuel

☐ **Chèque annuel :** Veuillez calculer vos primes au prorata (montant de la prime mensuelle X nombre de mois couvert) en fonction de la date du renouvellement annuel de la police. La période couverte est indiquée ci-dessus. Le chèque doit être émis à l'ordre de MédicAssurance inc.

AUTORISATION DE PRÉLÈVEMENTS BANCAIRES - DPA

J'autorise, par la présente, MédicAssurance inc. à prélever de mon compte, dont les coordonnées figurent sur le spécimen de chèque ci-joint, la somme de _____ $ le 1er jour de chaque mois et à rectifier le montant à débiter de mon compte advenant un changement de primes qui me sera signifié par un préavis 30 jours avant la date de la mise en vigueur de la modification.

SIGNATURE DU TITULAIRE DU COMPTE : _____ _____
(Les signatures électroniques ne sont pas acceptées) 1er signataire 2e signataire (s'il y a lieu)

DATE (jour / mois / année) : _____ TYPE DE SERVICE : ◯ Personnel ◯ Entreprise

Je peux révoquer mon autorisation à tout moment, en faisant parvenir un préavis de 30 jours à MédicAssurance inc.. Pour obtenir un formulaire d'annulation, ou pour plus d'information sur mon droit d'annuler un Accord de DPA (débits préautorisés), je peux communiquer avec mon institution financière ou visiter **www.cdnpay.ca**.

J'ai le droit de recevoir le remboursement de tout DPA qui n'est pas autorisé ou qui n'est pas conforme au présent Accord de DPA. Pour plus d'informations sur mes droits de recours, je peux communiquer avec mon institution financière ou visiter **www.cdnpay.ca**.

JOINDRE UN SPÉCIMEN DE CHÈQUE AVEC LA MENTION « ANNULÉ »
Photocopie acceptée

AUTORISATION DE PAIEMENTS PAR CARTE DE CRÉDIT

J'autorise, par la présente, MédicAssurance inc. (administrateur du régime), à prélever de ma carte de crédit le montant exigible en vertu du certificat d'assurance et à rectifier le montant à prélever de ma carte de crédit advenant un changement de primes qui me sera signifié par écrit 30 jours avant la date de la mise en vigueur de la modification. Je peux révoquer mon autorisation à tout moment en faisant parvenir un préavis de 30 jours à MédicAssurance inc.

◯ Visa ◯ MasterCard ◯ American Express

NUMÉRO DE LA CARTE : _____ DATE D' EXPIRATION (jour / mois / année) : _____

NOM DU DÉTENTEUR DE LA CARTE (tel qu'indiqué sur la carte) : _____

SIGNATURE : _____ DATE (jour / mois / année) : _____
(Les signatures électroniques ne sont pas acceptées)

CONSÉQUENCES D'UN DÉFAUT DE PAIEMENT

Vous êtes responsable des conséquences d'un défaut de paiement prévu au contrat d'assurance, c'est-à-dire lorsqu'un paiement n'a pas pu être effectué, quelle que soit la raison. Chez MédicAssurance inc., nous croyons qu'une erreur peut se produire et c'est pourquoi nous ne facturons aucuns frais additionnels la première fois que cette situation se produit. Cependant, à la deuxième occasion, des frais de 45 $ seront prélevés, chaque fois qu'un paiement préautorisé ne sera pas honoré par votre institution financière. MédicAssurance inc. effectuera alors le prélèvement impayé en même temps que le paiement préautorisé du mois suivant. Également, MédicAssurance inc. pourrait mettre fin au mode de paiement préautorisé et la prime annuelle serait alors exigée dans sa totalité pour tout contrat d'assurance visé par ce paiement préautorisé. Un arrêt de paiement préautorisé de votre part sans disposition ni entente au préalable avec MédicAssurance inc. pour le paiement de votre prime mensuelle pourrait entraîner l'annulation de tout contrat d'assurance visé par le paiement préautorisé.

DOCUMENT À REMPLIR ET À RETOURNER, ACCOMPAGNÉ
DU FORMULAIRE DE PROPOSITION D'ASSURANCE

Rév. 07/2018

PAYMENT AUTHORIZATION

Young Bar of Montreal
Policy 32385 - Period from May 1, 2018 to July 31, 2019

médicassurance
2197 Sherbrooke Street East, suite 200, Montréal (Québec) H2K 1C8
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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.