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Broker 1428 - Special Benefits Insurance
7th Fl - 366 Bay St
Toronto ON M5H 4B2

Phone: 416-601-0429 or 1-800-667-0429
Fax: 416-601-0308
e-mail: general@sbis.ca



Application

ELIGIBILITY

To be eligible for coverage under this plan:

- The applicant must:
 - be 65 years old or less; and
 - not be eligible for a provincial or territorial health insurance plan in Canada; and
- The applicant must:
 - be a student and provide proof of admission in a recognized Canadian institution of learning; or
 - be a student completing post-doctorate research in a recognized Canadian institution of learning.
- The applicant's spouse and child(ren) may be covered if the appropriate premium is paid. (See definitions of spouse and child(ren) on the back.)

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APPLICANT INFORMATION

F
 M

Last Name: _____ First Name: _____

Country of Origin: _____ Date of Birth (D/M/Y): ____/____/____ Date of Arrival in Canada (D/M/Y): ____/____/____

Please enclose proof of admission and registration at a recognized Canadian institution of learning. School Name: _____ Date of Enrollment (D/M/Y): ____/____/____

Address in Canada: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____ Email: _____

Beneficiary in case of death: _____

DEPENDENT INFORMATION

Spouse: Legally married Residing together for at least the last 12 months Date of Arrival in Canada (D/M/Y): ____/____/____

	LAST NAME	FIRST NAME	DATE OF BIRTH (D/M/Y)	SEX
Spouse:	_____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child:	_____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child:	_____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child:	_____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>

INSURANCE PERIOD and PAYMENT MODE

Desired Effective Date (D/M/Y): ____/____/____ Termination Date (D/M/Y): ____/____/____ Number of months of coverage: _____ Total Premium Due: _____

Cash Certified Cheque / Money Order (Please make payable to SBIS)

Visa Master Card Diners Club American Express

Credit Card Number: _____ Expiry Date (M/Y): ____/____

Cardholder's Signature: _____

MEDICAL AUTHORIZATION and DECLARATION

I understand that I must purchase the policy within 30 days from the earlier of the date of my arrival in Canada, or the date of my enrolment at a recognized Canadian institution of learning. I understand that if I am presently insured under an insurance policy administered by **etfs**, I must pay the insurance premium prior to the termination date of my existing policy. If I do not satisfy the above conditions, I understand that I will not be covered for a sickness occurring during the first 30 days of this insurance coverage.

I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. may investigate my claim. By signing this application, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.

Applicant's Signature: _____ Date (D/M/Y): ____/____/____

FOR OFFICE USE ONLY

Effective Date (D/M/Y): ____/____/____ Policy Number: _____

Expiry Date (D/M/Y): ____/____/____ Premium Paid: _____ 30-Day Penalty