HEALTH ASSOCIATION NOVA SCOTIA

APPLICATION FORM
CRITICAL ILLNESS (CDHA)

EMPLOYEE INFORMATION PLEASE USE CAPITAL LETTERS AND PRINT CLEARLY

First Name	Initial	Last Name	SIN
			- -

Address	City / Town	Province	Postal Code
Telephone Number ( )	Date of Birth (DD/MM/YY)	Gender (M/F)	

FAMILY INFORMATION

If you have eligible dependents, you must complete this section to ensure they are covered under the applicable benefit.

ELIGIBLE SPOUSE

01 - Last name	First name	Initial

If common-law, effective date of cohabitation (DD/MM/YY)	Date of birth (DD/MM/YY)	Gender (M/F)
/ /	/ /	

ELIGIBLE DEPENDENT CHILDREN

	Last name	First name	Initial	Gender M/F	Date of birth DD	MM	YY	Dependent Status*
02 -								
03 -								
04 -								

Indicate other dependent children on additional application form. * CH – Child; E - Student (college/university – **PROOF REQUIRED**); S - Disabled

CRITICAL ILLNESS FOR MYSELF *(up to a principal sum of $150,000, in units of $5,000)*

☐ No coverage

☐ Evidence-free coverage of: ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 **Mandatory:** Complete Declaration of Smoker Status below

Plus additional coverage of: $ _____ (Medical Questionnaire required – see below)

CRITICAL ILLNESS FOR MY SPOUSE *(up to a principal sum of $150,000, in units of $5,000)*

☐ No coverage

☐ Evidence-free coverage of: ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 **Mandatory:** Complete Declaration of Smoker Status below

Plus additional coverage of: $ _____ (Medical Questionnaire required – see below)

CRITICAL ILLNESS FOR MY DEPENDENT CHILDREN

☐ No coverage

☐ $10,000

IMPORTANT NOTES

Medical Questionnaire

To apply for Critical Illness coverage, you must request a copy of the Medical Questionnaire from your Benefits Administrator for all amounts (other than evidence -free coverage). **Coverage takes effect once the Medical Questionnaire has been approved.**

Critical Illness is available evidence-free only if you are applying for up to $25,000 of Critical Illness for yourself and your spouse.

DECLARATION OF SMOKER STATUS *(for Critical Illness for Yourself and Your Spouse)*

Member (complete only if changing your status):

Have you used any tobacco products within the past 12 months? ☐ Yes ☐ No

_____ _____

Date Signature of Employee

Spouse (complete only if changing your status):

Have you used any tobacco products within the past 12 months? ☐ Yes ☐ No

_____ _____

Date Signature of Spouse

PLEASE COMPLETE PAGE 2 ON OTHER SIDE →

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of determining their eligibility for benefits and any of the uses set out above. I authorize my employer(s) to notify Health Association Nova Scotia for purposes of initiating a claim for benefits or services that may be available to me or on my behalf under the plan.

I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting.

Date (DD/MM/YY) _____ Signature of Employee _____

Please forward the original to your Employer (Payroll & Benefits Department).

TO BE COMPLETED BY EMPLOYER ONLY

Division name	Division number	Payroll number	Location
CAPITAL DISTRICT HEALTH AUTHORITY (CDHA)	**051**		

Date of employment (DD/MM/YY)	Date of Permanent employment (DD/MM/YY)	☐ New ☐ Late applicant ☐ Other _____	☐ Permanent part-time ☐ Permanent full-time

Salary or wage per:	Guaranteed Hours			
☐ Hour ☐ Year _____	☐ Full-time _____ Hrs./Yr. ☐ Part-time _____ Hrs./Yr.	☐ Non-union ☐ Union Name _____	☐ Clerical ☐ Management ☐ Nursing	☐ Professional ☐ Service ☐ Technical

We hereby certify that this person is an eligible employee actively at work and performing the functions of his/her position.

Date (DD/MM/YY) _____ Signature of Employer _____

Please forward the original to Insured Benefits, Health Association Nova Scotia, 2 Dartmouth Road, Bedford NS B4A 2K7.