

Company Name: \_\_\_\_\_

Agent: \_\_\_\_\_

# Benecaid Medical Application

## Part 1: Applicant Information

Last Name	First Name	Middle Initial	
Street Number	Street Name	Unit Number	
City	Province	Postal Code	
Home Phone Number	Birthdate (MM/DD/YY)	Gender (M/F)	
Business Phone Number	Height (feet & inches)	Weight (lbs.)	

## Part 2: Dependent Information

Please complete the following

	Name of Dependent	Date of Birth	Relationship to Employee
A			
B			
C			
D			
E			

## Part 3: Medical Conditions

Have you or any of your dependents ever been diagnosed with or received medical treatment for any of the following? Please place a checkmark in the appropriate box and indicate which of your dependents each condition applies to. If yes, please provide details if necessary in space below.

Condition	No	Yes	Dependent
Heart Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting, or Blood Disorder			
Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease			
Diabetes, Colitis or Crohn's?			
Immune Disorders including testing for Immune Deficiency Syndrome (AIDS) Human Immune Syndrome (HIV).			
Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic fatigue or Fibromyalgia?			
Cancer, Tumor or Growth (except Basal Cell Carcinoma)			
Infertility/Reproductive Disorder/Menopause, Prostate Disorder			
Chronic Headaches, Migraines or recurrent infections			

  

Condition	No	Yes	Dependent
High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke) Stroke, Circulatory Disorder?			
Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?			
Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema.			
Auto-Immune Disorders – Systemic Lupus Erythematosus (S.L.E), Scleroderma			
Nervous, Mental, Emotional Disorders, Alzheimer, Parkinson's, Memory Loss or Seizure Disorder?			
Skin Disorder (including Acne)?			
Alcoholism or Drug Abuse/Dependency			
Other Condition/ Disease/Disorder/Injury- Please specify:			

Details to Yes Answer- Name of Condition, Date of Diagnosis etc.

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Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Part 4: Medications

Please complete the following including all medications currently prescribed

Name	Medical Condition	Medication	Daily Dosage	How long have you been taking it?

## Part 5: Hospitalization or Surgery

Please complete the following

Name	Medical Condition	Surgery or Treatment	Date of Hospitalization or Surgery

## Part 6: Family Physician

Please complete the following

Name	Address	Phone Number	Date of last visit

Reason for visit and results? \_\_\_\_\_

Any Future visits scheduled with any Medical or Paramedical Professional such as Chiropractor, Physiotherapist, etc.? Yes or No

If yes-What type of Practitioner is to be seen? \_\_\_\_\_

Reason for the visit? \_\_\_\_\_ Expected date of future visit? \_\_\_\_\_ (MM/YY)

I declare that I am currently in good health and that the information provided is complete and true to the best of my knowledge. I understand that the Application Form is part of the Health Insurance Agreement provided through Trent Health Insurance Services Corp. **I acknowledge that if at the time of claim it is discovered that any question in this Medical Application is not answered truthfully, accurately and completely, it will result in the non-payment of any claim and/or my policy will be null and void.**

\_\_\_\_\_  
Signature of Applicant / Spouse

\_\_\_\_\_  
Date

Please submit your completed application to:  
Benecaid Health Benefit Solutions Inc.  
2155 Leanne Blvd, Suite 228  
Mississauga, Ontario L5K 2K8

Local: 905-823-7397 Fax: 905-823-7374

Toll Free Phone: 1-877-797-7448 Toll Free Fax: 1-877-797-7449