

Johnson Personal Health Plan Application Form

for Individual Health and Dental Coverage

For Johnson Inc. Use Only			
Plan Sponsor Name:	Plan Sponsor ID Number:	Billing Division:	GSC ID Number: JAC

Note: Plan administered by Johnson Inc. Claims and risk managed by Green Shield Canada.

PLEASE PRINT AND COMPLETE THIS FORM IN FULL

SECTION A – Applicant Information

First Name	Initials	Last Name	
Address - Street/Apt.			Gender
City/Town			<input type="checkbox"/> Male
Province		Postal Code	<input type="checkbox"/> Female
Date of Birth	Provincial /Territorial Health Insurance Card No.		Daytime Telephone Number
Day Month Year			Area Code
Name of Employer / Association			
Email Address			

SECTION B – Coverage Information

1. I declare that I, and my spouse/partner and all listed dependents, have provincial or territorial health care coverage.
2. a) I/We are applying for: Single Coverage Couple Coverage Family Coverage
- b) I/We are selecting: **Optimum Plan** (Health, Prescription Drugs and Dental)
- Preferred Plan** (Health and Prescription Drugs, no Dental)
- Standard Plan** (Health and Dental, no Prescription Drugs)
3. a) Are you covered, or were you covered under any other health plan? Yes No
- b) If yes, please indicate if coverage was a/an Group Health Plan or Individual Health Plan
- c) When does/did your coverage end? Day:_____ Month:_____ Year:_____
- d) Name of insurance company: _____

SECTION C – Spouse/Partner and Dependent Information

First Name	Last Name	Provincial or Territorial Health Card Number	Gender M / F	Date of Birth Day / Month / Year	Student Ages 21 – 25 Yes / No	Disabled Yes / No
Spouse/Partner:						
Dependent:						
Dependent:						

Note: If additional space is required, please attach a separate, signed and dated sheet.

SECTION D – Statement of Health and Prescription Drug Information

Complete **SECTION D** if you are applying for the **Optimum Plan or Preferred Plan**. If you are applying for the **Standard Plan**, proceed to **SECTION E**.

Green Shield Canada reserves the right to perform claim audits from time to time to verify the accuracy of the health information provided.

1. Have you, your spouse/partner and/or any listed dependent been hospitalized in the last two (2) years?

Applicant	Spouse/Partner	Dependent
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Do you, your spouse/partner and/or any listed dependent expect to be hospitalized in the next six (6) months?

Applicant	Spouse/Partner	Dependent
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered “yes” to Questions 1 or 2, please provide details below:

First Name of Person	Date of Illness, Injury or Confinement Month/Year	Actual or Anticipated Number of Days in Hospital	Details/Outcome of Injury or Illness

Note: If additional space is required, please attach a separate, signed and dated sheet

3. Have you, your spouse/partner and/or any listed dependent **EVER** been treated for, consulted or received advice from a physician or specialist or had any indication of any of the following conditions? **Circle Yes or No for all questions AND circle the specific medical condition(s).**

Medical Condition	Applicant	Spouse/Partner (if applicable)	Dependent (if applicable)
a) Anxiety, Depression, Insomnia, ADD/ADHD, Eating disorders or any other Emotional, Mood, Behavioral or Mental health disorders	Y / N	Y / N	Y / N
b) Alzheimer's disease, Dementia, Parkinson's disease, Seizures/Epilepsy, Loss of consciousness, Multiple Sclerosis, Paralysis or any other Neurological disorders	Y / N	Y / N	Y / N
c) Kidney stones, Kidney Disease, Interstitial Cystitis, Benign Prostatic Hyperplasia (BPH) or any other Kidney, Bladder and Prostate disorders	Y / N	Y / N	Y / N
d) Liver disorders, including Hepatitis	Y / N	Y / N	Y / N
e) Infertility, Ovarian cyst, PCOS, Uterine Fibroids, Irregular menses, Menopause or any other Reproductive or Breast disorders	Y / N	Y / N	Y / N
f) Crohn's disease, Ulcerative Colitis, Irritable bowel syndrome, Ulcer, Hernia, Persistent heartburn/Reflux or any other Gastrointestinal disorders	Y / N	Y / N	Y / N
g) Heart disease, Stroke/ TIA (mini-stroke), Heart attack, Irregular heartbeat, Angina, High blood pressure, Elevated cholesterol or any other Circulatory, Heart or Vascular disorders	Y / N	Y / N	Y / N
h) Alcoholism or Drug dependency	Y / N	Y / N	Y / N
i) Skin disorders, including acne	Y / N	Y / N	Y / N
j) HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders	Y / N	Y / N	Y / N
k) Arthritis, Osteoporosis / Osteopenia, Back pain, Joint pain, Muscle pain, Fibromyalgia or any other Joint, Bone, or Muscular disorders	Y / N	Y / N	Y / N
l) Allergies, Asthma, COPD, Chronic Bronchitis, Emphysema, or any other Respiratory or Lung disorders	Y / N	Y / N	Y / N
m) Chronic headaches or Migraines	Y / N	Y / N	Y / N
n) Basal cell carcinoma, Growths, Polyps, Tumors, Leukemia or any other Cancers	Y / N	Y / N	Y / N
o) Cold sores, Herpes or any other Sexually transmitted diseases or infections (STDs or STIs)	Y / N	Y / N	Y / N
p) Diabetes/Elevated Glucose, Hypothyroidism, Hyperthyroidism, Adrenal Fatigue or any other Endocrine, Hormonal or Thyroid disorders	Y / N	Y / N	Y / N
q) Glaucoma, Cataracts, Meniere's disease or any other Eye, Ear, or Balance disorders	Y / N	Y / N	Y / N
r) Any other condition, disease, disorder, or injury not listed above: _____	Y / N	Y / N	Y / N

If you answered "yes" to any of the conditions in Question 3, please provide details below:

Question Letter	First Name of Person	Nature of Illness, Injury or Condition	Date of First Visit/Treatment Month/Year	Date of Last Visit/Treatment Month/Year	Drugs/Treatment	Result of Last Consult/ Current Status

Note: If additional space is required, please attach a separate, signed and dated sheet.

4. Do you, your spouse/partner and/or any listed dependent currently take or use any prescription drugs, have a prescription for which refills are currently authorized or expect to be using any prescription drugs? Prescription drugs include oral medication, injectables, creams, drops or serum.

Applicant	Spouse/Partner	Dependent
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes", please provide details below:

First Name of Person	Name of Drug/Medication/ Serum/Cream	Strength and Daily Dose of the Drug/Medication/ Serum/Cream	Daily Dosage of the Drug/Medication/ Serum/Cream	Length of Time on this Drug/Medication/ Serum/Cream	Number of Refills Per Year

Note: If additional space is required, please attach a separate, signed and dated sheet.

5. Have you, your spouse/partner and/or any listed dependent consulted a physician annually over the last two (2) years?

Applicant	Spouse/Partner	Dependent
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Provide the name and telephone number of the physician who holds the majority of your health records. If you do not have a doctor, indicate "NONE".

Name of Physician/Medical Clinic: _____ Telephone Number: _____

Johnson Inc.'s Commitment to Privacy

Your personal information is collected for the purpose of providing you with health and dental benefits, claims analysis and payments. For more information on Johnson Inc.'s privacy policies and procedures, visit johnson.ca.

