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HomeCare Assistance

ODYSSÉE ODYSSEY

PLACEMENTS - ASSURANCES - INVESTMENT - INSURANCE

Plan offered by *Odyssey Financial Group (a division of People Corporation)*
Underwritten by *Humania Assurance Inc.*

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AUTHORIZATION TO OBTAIN AND RELEASE PERSONAL INFORMATION TO A THIRD PARTY

NOTICE : This authorization applies to the insured, their spouse, as well as any dependents who are the subject of the insurance application.

In order to assess insurability, maintain your file and claims assessment, any individual or legal entity holding personal information about you including any health information, medical history or eligibility for claims, are authorized to transmit such information to the insurer, its agents or its reinsurers upon request. This includes physicians or other practitioners, hospitals, medical clinics or paramedical companies, laboratories, insurance companies or reinsurers, personal information agencies, financial advisors, any financial institutions, the owner, your employer or previous employer, the CNESST or other Workmen's Compensation Board, Canada or Quebec Pension Plan, the SAAQ or other Department of Motor Vehicles, the RAMQ or other provincial Health Departments, security and investigation agencies, claims and underwriting agencies, crime prevention or detection agencies.

Furthermore, the insurer or its agents are authorized to transmit the information to such third parties as well as its reinsurers. For the same purpose and to gather the same type of information, the insurer, its agents or its reinsurers may request an investigative report about you and to use information in their possession in other files.

This consent may also be used for a request for additional insurance or a contract modification.

AGREEMENT FOR THE ESTABLISHMENT OF A PERSONAL FILE

The insurer may retain the services of a specialized administrator to manage your insurance file as well as your claims.To ensure the confidentiality of your personal information, the insurer will establish a file in which such personal information will be held, and whose purpose is to allow you to benefit from an insurance coverage and additional financial services the company offers. Only authorized employees of the insurer or specialized administrator will have access to this file.

You may access your file and request the correction of any information if you demonstrate that it is inaccurate, incomplete, ambiguous, outdated or unnecessary.

To do so, a written request must be sent to the Officer in charge of the access to information to the Insurer's representative at the following address:

Odyssey Financial Group (a division of People Corporation)
3 Turgeon St,
Ste-Thérèse, Québec, J7E 3H2

Give this copy to the proposed insured

CLEAR FORM

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APPLICATION

☐ New enrolment Contract No.:

For agent use	Advisor information	Code	%
MGA (if applicable)	Name of advisor (administrator)		
	Name of advisor (2)		

1. INSURED INFORMATION

First Name: Last Name:

Date of Birth: _____/_____/_____ (DD / MM /YYYY) Gender: ☐ M ☐ F Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone: _____
Home Office Cell

E-mail:

2. OWNER (IF DIFFERENT FROM THE INSURED)

First Name: Last Name:

Date of Birth:_____/_____/_____ (DD / MM /YYYY) Gender: ☐ M ☐ F Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone: _____
Home Office Cell

E-mail:

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3. CHOICE OF COVERAGE

		Annual Premium $
HomeCare Assistance HomeCare, Supplies and Equipment	With Health coverage in case of Accident and Illness ☐ Plan 1 - $50,000 ☐ Plan 2 - $100,000	
	Without Health coverage in case of Accident and Illness ☐ Plan A - $75,000 ☐ Plan B - $125,000 ☐ Plan C - $200,000	
	Contract fee	
	Total annual premium	
	Monthly premium = Annual premium x 0.09	

If a couple subscribes to HomeCare Assistance at the same time, a discount of 10% is applicable for both the insured and the following spouse:

Name	Relationship

4. BANKING INFORMATION

Please attach a blank cheque marked "VOID" with the application

Name of Financial Institution:

Address of Financial Institution:

Insert the numbers found on the bottom of the cheque, as shown in the following example:

Branch Number:	Financial Institution Number (Bank):	Account Number:

5. PREMIUMS AND METHOD OF PAYMENT

☐ **Monthly Pre-authorized debit $**_____(See section 6)
A first withdrawal will be taken on the approval date. Thereafter, the withdrawal date will be the same as the issue date (except if the 29th, 30th, 31st, withdrawal date will be the 1st of the month).

☐ **Annual Pre-authorized debit $**_____(See section 6)
The initial withdrawal date will be the same as the date of issue of the contract. Afterwards, the withdrawal date will be the same as the renewal date.

☐ **Annual $** _____

Make cheque payable to Odyssee Insurance in Trust.
Odyssee Insurance is the third party administrator on behalf of Humania Assurance**.**

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6. PRE AUTHORISED DEBIT (PAD) AGREEMENT

Only fill out for a NEW insurance POLICY, if PAD was chosen in the application.

Banking Information	Please attach a blank cheque marked « **VOID»**.
Type of Service (check the appropriate box)	☐ **PERSONAL** — If debit is from a personal account ☐ **BUSINESS** — If debit is from a corporate account
Withdrawal Arrangements This pre-authorised agreement is considered a variable one.	1. I authorize the insurer's representative to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. **2.** If a pre-authorised debit is returned due to insufficient funds (NSF) in the account, the insurer's representative, will withdraw the amount again from the same bank account, without prior notice. **Any fees resulting from insufficient funds (NSF) in the account will be added to the subsequent debit.** 3. I agree to the debiting of my account on the regular pre-authorised debit (PAD) withdrawal day as indicatedon the application or the next business day (Subject to change).
Waiver	**I Waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic Withdrawal or a change in the date of the Withdrawal.** *
Cancellation	You may cancel this pre-authorized debit agreement at any time, subject to providing the insurer or its authorized representative with 10 days' written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca.)
Method of Payment	Any cancellation of this pre-authorized debit agreement will not affect the agreement between you and the insurer whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit www.cdnpay.ca.
Exclusive Rights	All amounts transferred from the pre-authorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance contract.

*The insurer or its authorized representative will not increase your pre-authorized debit or change your debit date after your insurance contract becomes effective without notifying you.

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7. NAME, SIGNATURE AND TITLE OF PAYERS (ACCOUNT OWNERS) FOR « PAD»

If two signatures are required to sign on the account, both account owners must sign this Authorization.

If the Account Owner is a legal entity (corporation, association, etc.), the signature of the authorized individuals with their title is required.

PRE-AUTHORIZED DEBIT AGREEMENT: In the event that this declaration is for the addition of a contract rider or of a contract instead of a rider on an existing contract simply because the agent is not the agent (administrator) on the existing contract, you hereby acknowledge and agree that the banking information on file for the existing contract will be used for the rider or contract referred to in this declaration, including the withdrawal date. In the case of a contract instead of a rider on an existing contract simply because the agent is not the agent (administrator) on the existing contract, you also agree to the withdrawal of the first premium from the date of issue of the existing contract to which this declaration applies. Subsequent premiums will be withdrawn on the same date as the existing contract's premiums.

Name: _____

Title: _____

Signature: X _____ Date: _____

Name: _____

Title: _____

Signature: X _____ Date: _____

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8. HEALTH DECLARATION

	YES	NO
A - Medical History - Past Five (5) Years		
Have you been hospitalized as a result of a suicide attempt, depression, anxiety, chronic fatigue, or any other mental health disorder	○	○
B - Medical History - Past Three (3) Years		
Have you received treatment or been medically advised to reduce your consumption of alcohol or drugs due to a dependency	○	○
C - Personal Health History - Have you ever suffered from any of the following conditions:		
HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome)	○	○
Heart failure or Cardiomyopathy	○	○
Heart Rhythm Disorder requiring a pacemaker where I am not stable and am unable to perform any daily activities of living such as moving independently, bathing, dressing, toileting, maintaining continence, feeding myself without assistance	○	○
Presently being treated for cancer, diagnosed with metastatic cancer, or had two or more cancers in the past (other than basal cell carcinoma), including cancer recurrence	○	○
Two or more episodes of stroke, paralysis, or two or more transient ischemic attacks (TIA)	○	○
Liver cirrhosis or chronic hepatitis	○	○
Insulin-dependent diabetes requiring more than 40 units of insulin daily	○	○
Chronic renal disease, been or currently on dialysis, undergone or awaiting an organ transplant	○	○
Amputation as a result of illness	○	○
Ataxia, transverse myelitis, myasthenia	○	○
Cystic fibrosis, pulmonary fibrosis, or chronic respiratory disease requiring the use of oxygen	○	○
Motor neurone disease, amyotrophic lateral sclerosis, primary lateral sclerosis, Kennedy syndrome, multiple sclerosis, Parkinson's disease, Huntington's Chorea	○	○
Dementia, Alzheimer's disease, or any form of Memory Loss	○	○
Bladder or bowel incontinence requiring regular use of incontinence supplies	○	○
Dizziness, loss of consciousness or numbness for which no diagnosis has been made	○	○
Osteoporosis with fractures or systemic lupus erythematosus	○	○
Awaiting an investigation or scheduled surgery that has not been yet completed	○	○

Current Health Status:

I am not currently receiving, nor have I been advised to receive care in a hospital, psychiatric, convalescence home, or rehabilitation center.

I am not receiving physiotherapy at home, nor do I require the assistance of medical accessories such as a cane, walker, or wheelchair.

I confirm that I have not received any diagnosis of cognitive impairment and confirm being able to perform regular daily living activities such as moving independently, bathing, dressing, toileting, maintaining continence, feeding myself without assistance.

Signed at _____ this _____ day of _____ , 20____
(province)

Signature : _____
Signature of the proposed insured

Signature : _____
Signature of the advisor or witness

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9. DECLARATIONS, AUTHORIZATIONS AND SIGNATURES

- I confirm that each eligible proposed insured holds a valid card from his/her provincial health government plan.
- I confirm that the information and answers that I have provided in this document are true.
- I confirm that the information and answers that I have provided are true and complete and acknowledge that they constitute the basis of my insurance coverage.
- I understand that if any answer is false or incomplete, any insurance coverage granted may be voided.
- I understand that I may be refused for insurance coverage if, in the opinion of the insurer, I am not insurable for the insurance coverage.
- I understand that any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date insurer makes a decision must be reported to the insurer.
- I understand that if I fail to do so, any insurance coverage granted may be voided.
- I confirm that I will keep a copy of this document.
- I acknowledge having been notified that the financial advisor is to be paid by commission in relation to the transactions described in this insurance application. I have been inform the he/she is independant of the insurer and is not its representative.
- I authorize the insurer to deposit all my claim reimbursements to the designated bank account.
- I acknowledge receipt of the **Authorization to obtain and release personal information to a third party** and the **Agreement for the establishment of a personal file.**
- This authorization is valid for the purposes of this contract, its modification, or its reinstatement.
- I acknowledge that a reproduction of this authorization shall be as valid as the original.
- I authorize Odyssey Financial Group (a division of People Corporation) to use my personal information in order to send me information on other products and services that might interest me. If no, please check (√) the following: ☐ I do not authorize this use.

Signed at _____, this _____ day of _____ , 20____.
(Province)

Signature : _____
Signature of the proposed insured

Signature : _____
Signature of the advisor

Signature : _____
Signature of the owner