



enVia
HEALTH SPENDING ACCOUNT



eHSA Health Spending Account

Best for Incorporated Contractors. One revolutionary benefits program.

With an enVia Health Spending Account, you'll enjoy a much broader range of claimable health & dental expenses - and freedom from the annual cost increases typical of traditional benefit plans - with no wasted premiums, deductibles or co-payments.

Key Features:

- Much wider range of claimable expenses
- No wasted premiums - you only pay for the health & dental benefits you actually use
- Not a traditional insurance plan, rather a tax-deductible "private health services plan" allowing you to write off your health & dental expenses
- Pay-Direct drug & dental card included at no extra charge for efficient, speedy claims payment
- Automatically includes "Catastrophic Insurance" to cover any sudden, unanticipated expensive claims for prescription drugs, hospital or private duty nursing



Includes Pay-Direct
Drug & Dental Card



How does it work?

It's like a Health & Dental bank account - you make monthly/annual tax-deductible deposits, then use those funds for healthcare expenses.

What expenses does an HSA cover?

The HSA opens up a whole new world of claimable expenses not covered under traditional plans, all with 100% reimbursement and no deductibles or co-pays!

Here are some sample expenses you can claim with an HSA:

Acupuncture*	Contact Lenses**	Hydrotherapy**	Oxygen & Equipment	Therapy Equipment
Artificial Limbs	Contraceptive Devices**	Insulin & Diabetic Supplies	Physiotherapist	Vein Removal
Athletic Therapy*	Crowns & Bridgework	Laser Eye Surgery	Podiatrist	Viagra, Cialis, Levitra
Attendant Care	Dental Implants & Veneers	Naturopathic Products**	Prescription Drugs	Vitamins**
Birth Control Pills**	Dental Treatment	Occupational Therapist	Psychologist	Wheelchairs
Breast Reduction Surgery	Dentures	Optician	Psychotherapy*	X-rays
Chinese Medicine*	Dermatologist Fees***	Optometrist	Psychiatrist	& more****
Chiropractor	Fertility Treatments	Orthodontics / Dental Braces	Registered Masseur	
Chiroprapist	Gastric Bypass / Stapling	Orthopedic Shoes	Non-Cosmetic Skin Care***	

* Must be performed by a licensed medical practitioner;

** Must be prescribed by a licensed medical practitioner and dispensed by a licensed pharmacist / medical practitioner as part of their medical services;

*** Must be medically necessary;

**** As per Section 118.2 (2) of the Federal Income Tax Act and Interpretation Bulletin IT-519R2.

CALL TODAY 905-554-0875

www.maclagan.ca

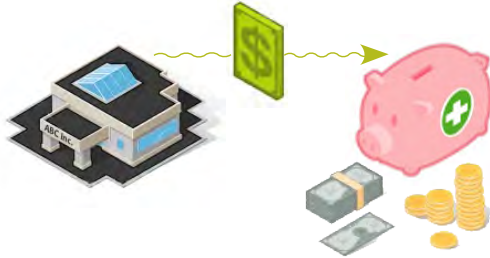
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For most people, the **enVia Health Spending Account** represents a new way of covering your Health & Dental Expenses. Please review the following key points to learn how this program is different from a traditional group insurance plan. We're happy to answer any questions you may have - please contact us as indicated below if you need more information!

A How the enVia Health Spending Account (eHSA) works:

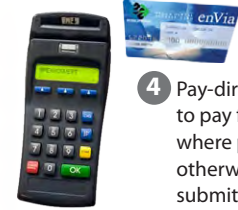
1 First, the Employer (or you, if self-employed or owner) determines an annual contribution amount per employee ranging from \$1,000 to \$50,000 or more.

2 Next, monthly employer contributions are deposited to individual employee accounts.



Date	Transaction Description	Amount		eHSA Balance
		Debit	Credit	
Jan 1	Initial Employer Contribution		\$125.00	\$125.00
Jan 6	Prescription Drug Claim	\$75.00		\$50.00
Feb 1	Monthly Employer Contribution		\$125.00	\$175.00
Feb 15	Massage Therapy Claim	\$60.00		\$115.00
Mar 1	Monthly Employer Contribution		\$125.00	\$240.00
Mar 12	Eyeglasses Claim	\$300.00		-\$60.00
Apr 1	Monthly Employer Contribution		\$125.00	\$65.00

3 Employee uses funds in eHSA to pay for health & dental expenses. Current balance can be checked online 24/7.



4 Pay-direct Card used to pay for expenses where possible, otherwise employee submits paper receipt for reimbursement.

5 Reimbursement is 100% with no deductible or co-pay. If current balance is less than submitted claim, reimbursement will be made once monthly contributions allow.

B What is Catastrophic Insurance & how does it work?

Your eHSA automatically includes **\$25,000 per year (\$1 million lifetime) of Catastrophic Insurance** to provide an additional "umbrella of protection" in the event of a sudden serious illness or disease.

When would I use it?

Think of the eHSA as covering your "everyday" or even elective health & dental expenses, and for most people it will be all you ever use. But, if through illness or injury, you suddenly had expenses for expensive prescription drugs or home nursing, for example, then you could use your Catastrophic Insurance to cover the cost.

What does it cover?

Catastrophic Insurance covers Drug, Hospital or Private Duty Nursing (out-of-Hospital) expenses **only**. It does not cover any dental expenses or elective medical expenses.

Are there any limitations?

Yes, there are two limitations or conditions you should be aware of:

First, Catastrophic Insurance only "kicks in" once your claims for Drug, Hospital or Private Duty Nursing have exceeded a deductible of \$2,500 per person per policy year.

Secondly, while no health evidence is required, **there is a 24 month waiting period for pre-existing medications or conditions.**

Note: these limitations apply **only** to the Catastrophic Insurance. **There is no deductible or waiting period for your eHSA claims.**



C What happens to unused eHSA contributions at year end?

Unused contributions from the first plan year are not lost – they carry forward to the second plan year, and if not used by the end of that plan year are forfeited back to the employer.

The one exception to this is for Sole Proprietors, who Revenue Canada rules are not eligible to receive the forfeiture of unused eHSA funds at the end of each second plan year. Instead, Sole Proprietors are limited by the Income Tax Act to deduct \$1,500 for themselves, \$1,500 for their spouse and \$750 / child from their business income as qualifying medical insurance premiums.



Accordingly, **Sole Proprietors with high medical or dental expenses should seriously consider the financial advantages of incorporation**, as there is no limit placed on contributions to a private health services plan. Fortunately, the **enVia Benefits Program offers access to discounted Incorporation Services** should you have need.

D What if I already have benefit coverage through my spouse?

This is quite common, and the eHSA actually works to your advantage when combined with any other group or individual coverage, because **you decide whether you wish claims to be claimed first against your eHSA, or any other insured benefits** that you are also covered by, such as a spouse's program.

This flexibility is very useful, since **you can claim from your eHSA any co-insurance amounts or deductibles** that you must pay out-of-pocket on the spouse's program.

You should also look closely at enVia's Optional Benefits, which may offer additional coverage that's not available in your spouse's program.

Welcome to the enVia eHSA Benefits Program!

We know that filling out insurance applications can sometimes be confusing and complicated, so we've made every effort to simplify the process. Please use the following points to assist you in completing the necessary forms. They will help you to complete the application accurately and allow us to process your information as quickly as possible.

Under this Program, your employer or incorporated company contributes a "defined annual amount" to your enVia Health Spending Account (eHSA). The key features of an eHSA are

- The eHSA is like a personal health and dental bank account that can be used to pay exclusively for medical and dental expenses, and other expenses not fully covered under other medical and dental plans.
- A much broader range of medical & dental expenses are claimable compared to a traditional group insurance program.
- You determine how to spend the available funds.
- You can also use the eHSA to pay for expenses for financially dependent members of your extended family, such as your parents, your grandparents or your grandchildren, who are not normally eligible under medical or dental plans.

What kind of expenses can I claim from my eHSA?

Probably a lot more than you'd think, and definitely a lot more than under any traditional group insurance plan. You'll find a listing of eligible expenses in the program flyer, or you can check our website at http://www.maclagan.ca/health_spending_account.html

What if I don't spend all of the available funds in a given year?

It is important to budget your available eHSA funds, and to seek the lowest cost medical or dental service provider. Any remaining positive eHSA balance at the end of a policy year cannot be refunded, but will be carried forward to the next Plan Year. If not used by the end of the 2nd year, it is forfeited back to the contributing employer (or your incorporated company) as per Canada Revenue Agency rules.

What are Optional Benefits?

While the eHSA addresses your health & dental protection, Optional Benefits offer additional insurance to allow you to tailor your benefit coverage to meet your particular needs. The Optional Benefits include Disability Income Protection, Accidental Death & Dismemberment Insurance, Critical Illness Recovery Program, Life Insurance and Travel Insurance.

Which Forms do you need to complete?

You need to complete:

1. The attached **enVia Health Spending Account Application Form**
2. The attached **enVia Esorse Client PAC Authorization Form**
3. The attached **enVia Chronic Conditions Reporting Form**
4. The Personal Health Declaration, **only** if applying for the Optional Disability Income Protection (TTD and/or PTD).

How to Complete the Application Form:

1. Fully complete the General Information Section. Please ensure that you provide an email address and phone numbers where you can be contacted if the Administrator requires additional information.
2. In Section 2 please provide details of your eligible dependents. If your spouse has group health or dental coverage, please provide the name of the employer; the policy number and the name of the insurer. This is required so that the claims can be coordinated between the eHSA Program and the spouse's program.
3. Under Section 3.1 please indicate the coverage required, i.e. **Single, Couple** or **Family**. (Couple can include a Single Parent w/1 child)
4. In Section 3.2 indicate the annual amount of your incorporated company's contribution to your eHSA, and use the table to determine your monthly cost.
5. Section 4 allows you to choose your **Optional Benefits**. Start by determining your Occupational Class, then select any or all of the five Optional Benefits, and calculate your monthly cost for each. Note that a separate, online application and payment by credit card is required for the XN Global® Preferred Care Insurance - please contact us for instructions.
6. **ONLY** If you are purchasing the **Optional Accidental Death & Dismemberment (AD&D) coverage** complete the **AD&D Beneficiary Designation** below.
7. In Section 5 calculate your total monthly cost as per the instructions and place that amount in the box.
8. Sign and Date the Application in Section 6, and forward it to the address indicated.
9. **If you are applying for Optional Disability Benefits**, please complete and submit the attached Personal Health Declaration.

Questions, or if you require assistance, please contact the Administrator, **MACLAGAN INC.** at one of the numbers below:



enVia Health Spending Account (eHSA) Application Form

1 Your General Information

Effective Date of Coverage Requested: _____

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="radio"/> MARRIED <input type="radio"/> SINGLE <input type="radio"/> COMMON-LAW <input type="radio"/> OTHER _____			
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	LANGUAGE <input type="radio"/> ENGLISH <input type="radio"/> FRENCH		PRIMARY OCCUPATION		ANNUAL EARNINGS
HOME ADDRESS			CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE		WORKPLACE TELEPHONE			FAX	
EMAIL ADDRESS			YOUR BUSINESS TYPE OR EMPLOYMENT STATUS <input type="radio"/> EMPLOYEE <input type="radio"/> SELF-EMPLOYED (INCORPORATED) <input type="radio"/> SELF-EMPLOYED (SOLE PROPRIETOR)			
YOUR BUSINESS OPERATING NAME		YOUR BUSINESS ADDRESS		CITY	PROVINCE	POSTAL CODE
YOUR AGENT / BROKER'S NAME (IF APPLICABLE)		AGENT / BROKER'S TELEPHONE:		AGENT / BROKER'S E-MAIL ADDRESS:		
AGENT / BROKER'S ADDRESS:			CITY	PROVINCE	POSTAL CODE	

2 Your Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 19
Spouse:				
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED
Child:				<input type="radio"/> STUDENT <input type="radio"/> DISABLED

If a Child is over age 19, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
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3 Your enVia Health Spending Account (eHSA) Coverage (includes \$25,000 of Catastrophic Insurance)

1. Please indicate your level of coverage: Single Couple Family

2. Choose your Annual eHSA Contribution Amount: Note: If you are completing the application as an employee, your contribution amount will have been pre-determined by your employer and the amount communicated to you.

Net Annual Amount Required in eHSA	<input type="radio"/> \$1,000 (\$83.33/mo)	<input type="radio"/> \$1,500 (\$125.00/mo)	<input type="radio"/> \$2,000 (\$166.67/mo)	<input type="radio"/> \$3,000 (\$250.00/mo)	<input type="radio"/> \$5,000 (\$416.67/mo)	<input type="radio"/> \$6,000 (\$500.00/mo)
Monthly Cost*	\$112.00 Single \$124.00 Couple \$130.00 Family	\$162.00 Single \$174.00 Couple \$180.00 Family	\$212.00 Single \$224.00 Couple \$230.00 Family	\$312.00 Single \$324.00 Couple \$330.00 Family	\$512.00 Single \$524.00 Couple \$530.00 Family	\$612.00 Single \$624.00 Couple \$630.00 Family
Net Annual Amount Required in eHSA	<input type="radio"/> \$7,200 (\$600.00/mo)	<input type="radio"/> \$10,000 (\$833.33/mo)	<input type="radio"/> \$12,000 (\$1,000.00/mo)	<input type="radio"/> \$15,000 (\$1,250.00/mo)	<input type="radio"/> \$25,000 (\$2,083.33/mo)	<input type="radio"/> \$50,000 (\$4,166.67/mo)
Monthly Cost*	\$684.00 Single \$696.00 Couple \$702.00 Family	\$945.33 Single \$957.33 Couple \$963.33 Family	\$1,132.00 Single \$1,144.00 Couple \$1,150.00 Family	\$1,412.00 Single \$1,424.00 Couple \$1,430.00 Family	\$2,345.33 Single \$2,357.33 Couple \$2,363.33 Family	\$4,678.67 Single \$4,690.67 Couple \$4,696.67 Family

How much should I contribute this year?

If you are the employer, or self-employed (whether incorporated or a sole proprietor), you choose the annual contribution amount once each year. You should try as best as possible to make a reasonable estimate of anticipated Health & Dental expenses over the coming year. Keep in mind that unused funds from the first year carry over into the second, and if still unused at the end of year two are returned to the employer (except for Sole Proprietors - see Key Concepts for details).

Also bear in mind that if your anticipated expenses for this year are, for example, \$2,000 you could establish that amount as your eHSA for year 1 and then increase it the following year to cover an upcoming large expense such as Orthodontia for a child, or laser eye surgery, for example.

Net Annual Amount Required in eHSA: \$ _____

Monthly Cost (*includes Catastrophic Premium, Administration Fees & Applicable Taxes): \$ _____ / month (a)

4 Choose your Optional Benefits

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. In some cases, a separate application form may be required.

Determine your Occupational Class: Insurers base their rates for some coverage in part on the nature of the work being performed as part of your regular duties. Use the table below to determine your Occupational Class for Life, TTD, PTD and AD&D Coverage. Please contact us if it's not clear what category matches your particular job.

<input type="radio"/> Class 1	All Administrative Office Staff, Office based Managers, Accountants, Sales Staff, IT Staff, Graphic Designers, Real Estate Agents, Lawyers, Retail Sales Staff.
<input type="radio"/> Class 2	All on-site Managers and Superintendents at Mining & similar Operations, Lab Technicians.
<input type="radio"/> Class 3	Nurse, Physiotherapist, Massage Therapist, Personal Support Worker, Nannies, Hospital Cleaning Staff, Light Industrial Workers.
<input type="radio"/> Class 4	All on-site manual workers not exposed to unusual accident risks such as Foreman, Electricians, Finish Carpenters, Plumbers, Cooks, Courier Drivers, Short Haul Truck Drivers, Auto Body Painters, Daycare Worker, Flooring Installers, Cement Layers & Finishers, Painters, and Other Skilled Trades.
<input type="radio"/> Class 5	All on-site heavy manual workers exposed to considerable accident risks, such as Rough Carpenters, Industrial Mechanics, Auto Mechanics, Steamfitters, Farmer, Movers, Restaurant Server, Long Haul Truck Driver, Landscape Workers, and Bricklayers.

a) XN Global® Preferred Care Program: Requires separate Application Form & Health Statement, but please indicate here if you will be purchasing coverage.

b) Temporary Total Disability Benefits (TTD): Following a 30 day waiting period, benefit payable is 66.67% of weekly earnings to a maximum of \$1,500 week.

Occupational Class (from table above)	Rate per \$10 of benefit per month	Monthly Cost per \$500 of weekly benefit	Monthly Cost per \$750 of weekly benefit	Monthly Cost per \$1,000 of weekly benefit	Monthly Cost per \$1,500 of weekly benefit (maximum)
Class 1	\$0.458	\$22.90	\$34.35	\$45.80	\$68.70
Class 2	\$0.488	\$24.40	\$36.60	\$48.80	\$73.20
Class 3	\$0.614	\$30.70	\$46.05	\$61.40	\$92.10
Class 4	\$0.663	\$33.15	\$49.73	\$66.30	\$99.45
Class 5	\$0.780	\$39.00	\$58.50	\$78.00	\$117.00

Weekly Earnings \$ _____ X 66.67% = Weekly Benefit \$ _____ ÷ 10 = _____ X Class Rate per \$10 _____ = **Monthly Cost \$ _____ (b)**
(MAXIMUM \$1,500)

c) Permanent Total Disability Benefits (PTD): Provides a benefit of up to 5X annual earnings after 25 months

Occupational Class (from table above)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000
Class 1	\$0.040	\$2.00	\$10.00	\$20.00
Class 2	\$0.056	\$2.80	\$14.00	\$28.00
Class 3	\$0.079	\$3.95	\$19.75	\$39.50
Class 4	\$0.110	\$5.50	\$27.50	\$55.00
Class 5	\$0.154	\$7.70	\$38.50	\$77.00

Annual Earnings \$ _____ X 5 = PTD Benefit \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$ _____ (c)**
(MAXIMUM \$500,000)

d) Accidental Death & Dismemberment: No Health Statement required. Available in multiples of \$50,000 to a maximum of \$500,000.

Occupational Class (from table above)	Monthly Rate / \$1,000	Monthly Premium / \$50,000	Monthly Premium / \$250,000	Monthly Premium / \$500,000 (maximum benefit)
Class 1	\$0.09	\$4.50	\$22.50	\$45.00
Class 2	\$0.10	\$5.00	\$25.00	\$50.00
Class 3	\$0.12	\$6.00	\$30.00	\$60.00
Class 4	\$0.15	\$7.50	\$37.50	\$75.00
Class 5	\$0.20	\$10.00	\$50.00	\$100.00

Coverage required \$ _____ ÷ 1000 = _____ X Class Rate per \$1,000 _____ = **Monthly Cost \$ _____ (d)**
(MAXIMUM \$500,000)

e) Limited Pay Permanent Life Insurance: In units of \$25,000 or \$50,000. Requires separate application and medical underwriting.

Yes, please provide me with a quotation.

AD&D Beneficiary Designation: (please complete this section ONLY IF APPLYING FOR OPTIONAL AD&D COVERAGE)

REVOCABLE IRREVOCABLE

BENEFICIARY(IES) SURNAME(S), GIVEN NAME(S) & INITIAL(S) _____

RELATIONSHIP OF BENEFICIARY TO INSURED _____ **If beneficiary is under age of majority, please complete TRUSTEE section**
I, the undersigned applicant, hereby appoint the person(s) stated as my beneficiary(ies) on my current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future.

Applicant's Signature **X** _____ Date _____

DECLARATION APPOINTING TRUSTEE (complete if beneficiary is under age of majority)

I do hereby appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority and declare receipt of such Trustee shall be in good discharge to the insurer for the amount so paid. And I hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at _____ this _____ day of _____ 20 _____

Applicant Signature _____

5 Calculate your Monthly Cost:

1. enVia Health Spending Account (eHSA) Monthly Cost:

Enter amount from line (a) on page 1

\$ _____ (1)

2. Optional Benefits Cost:

Total the amounts from lines (b) through (d) to determine your monthly Optional Benefits cost.

\$ _____ (2)

3. Your Total Monthly Cost:

Total lines 1 and 2 to determine your Total Monthly Benefits Cost. This amount will be withdrawn from your financial institution each month. Note: If you are also applying for XN Global® Preferred Care Insurance or Life Insurance (requires a separate application) the monthly premium for that coverage is billed separately.

\$ _____

Total Monthly Benefits Cost

IMPORTANT:

You must also complete the attached enVia Esorse PAC Authorization Form to authorize monthly contributions via cheque or credit card.

6 Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

I authorize, as appropriate, either my employer to withdraw from my pay OR the Plan Administrator to withdraw from my financial institution, the required insurance premiums / health spending account deposits, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary.

Signed at: _____ this _____ day of _____, _____ Applicant's Signature _____
CITY / TOWN PROVINCE DATE MONTH YEAR

Mail or Fax your completed application to:

enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

This Program is made available through the corporate licence of Maclagan Inc. in Ontario, and Financial Horizons Group provincial licences in all provinces outside of Ontario.

Phone: (416) 446-0115

Fax: (416) 446-7371

E-mail: info@maclagan.ca

Privacy & Confidentiality We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to the Plan Administrator's Customer Service Dept., the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.



ESORSE
CORPORATION

ESORSE CORPORATION
234 Eglinton Ave. East, Suite 502
Toronto, ON M4P 1K5
Tel: 416-483-3265 Toll-free: 1-877-637-6773



enVia
HEALTH SPENDING ACCOUNT

Request for Pre-Authorized Withdrawal

Purpose:

This form is required to establish or make changes to the pre-authorized payments required for your insurance premiums or health spending account. You can choose to make payments via withdrawals from your chequing account or charges to your credit card.

My Information:

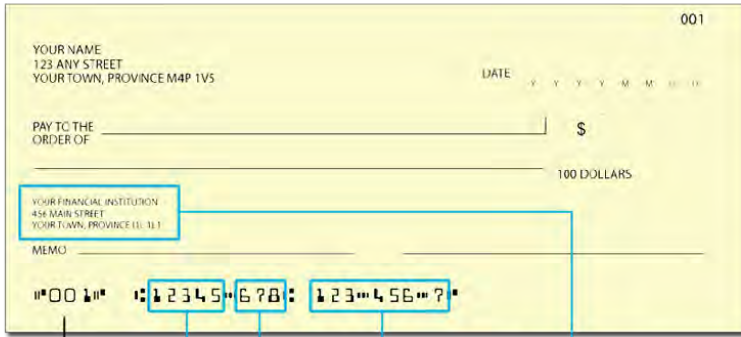
Name: Company / Employer Name:

Address: Phone:

Email: I wish to pay by: Cheque Credit Card

My Bank Information (if paying by cheque):

Using the sample cheque image as a guide, please provide the requested information to enable your monthly pre-authorized payments.



Bank Name:

Branch Address:

Bank Number:

Transit Number:

Account Number:

Cheque Number Bank Number Transit Number Account Number Bank Name & Address If you are unsure of your banking information, please attach a copy of one of your cheques marked "VOID".

My Credit Card Information (if paying by credit card):

Card Type: VISA MASTERCARD

Name as it appears on card:

Credit Card Number: Expiry Date: /

Authorization Agreement:

I hereby authorize Esorse Corporation to make automatic withdrawals for my insurance premiums and/or health spending account, either from my account at the financial institution named below, or charged to the credit card specified below.

I understand that premiums will be withdrawn on the 28th of each month for the month following.

Further, I understand that Esorse Corporation will terminate my pre-authorized payment plan if any withdrawal is reversed by my financial institution, and that this form authorizes Esorse Corporation to charge a fee for any pre-authorized payments not honored by my financial institution.

This agreement will remain in effect until Esorse Corporation receives a written notice of cancellation from me, or until I submit a preauthorized withdrawal form.

Authorized Signature: **X** _____ Date: _____

Please complete & sign this form and fax it to: (416) 446-7371



PRIVATE & CONFIDENTIAL

Pre-Existing / Chronic Condition Reporting Form for Catastrophic Insurance

Purpose: To report confidentially any chronic or pre-existing conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed under the Catastrophic Insurance Policy. **THIS ONLY APPLIES TO THE CATASTROPHIC INSURANCE - YOUR HEALTH SPENDING ACCOUNT STILL ALLOWS YOU TO CLAIM ANY ELIGIBLE EXPENSE FROM DAY ONE.**

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed under the Catastrophic Insurance Policy.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Administrator, Norfolk Mobility Benefits, Calgary, Alberta and Esorse Corporation, the provider of the enVia Pay-Direct Drug Card.

Name: _____ Employer: _____

Email: _____ Home Tel: _____ Work or Mobile Tel: _____

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

(Signed)

(Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

Or FAX this form to: 416-446-7371

If you have any questions or require assistance please contact:

John Maclagan at: 416-446-0115; email: jmaclagan@sympatico.ca OR Scott Maclagan at: 905-554-0875; email: esmaclagan@rogers.com



Personal Health Declaration

Please complete this Personal Health Declaration accurately and in full. In particular, if you answer "YES" to any of the medical questions below, please provide details on reverse. If you have questions or need further assistance, please call us at (905) 554-0875

Section 1: Applicant Information

APPLICANT NAME	DATE OF BIRTH (DAY / MONTH / YEAR)	APPLICANT'S HEIGHT _____ ft/in or _____ cm	APPLICANT'S WEIGHT _____ lbs or _____ kg
NAME OF APPLICANT'S EMPLOYER	DATE EMPLOYED (DAY / MONTH / YEAR)	CERTIFICATE OR PAYROLL NUMBER (OFFICE USE ONLY)	
OCCUPATION	NORMAL NUMBER OF HOURS WORKED PER WEEK	DIVISION / CLASS (OFFICE USE ONLY)	

Section 2: Health Declaration

Have you ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on reverse.

	APPLICANT
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematous (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you currently taking or have you been prescribed any prescription medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing piloting aircraft, or bungee jumping?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Full name and address of your regular attending physician:

If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. **If the answer is "none", state "none"**

NAME OF APPLICANT'S PHYSICIAN		ADDRESS
LAST VISIT (MONTH / YEAR)	REASON	RESULT

For each "YES" answer to any of the questions above, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on the next page.

