SPECIAL MARKETS solutions

Application for MISHIP Inpatriate Coverage
(Manitoba International Student Health Insurance Plan)

Please print in ink

POLICY NO. 100009313 **NAME OF UNIVERSITY, COLLEGE OR SCHOOL:** ____

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME AND MIDDLE INITIALS	GENDER ❑ Male ❑ Female	DATE OF BIRTH (DD/MMM/YYYY)
STREET ADDRESS IN CANADA	CITY	PROV MANITOBA	POSTAL CODE
EMAIL ADDRESS		HOME TELEPHONE NO. ( ) -	CELL PHONE NO. ( ) -
DATE OF ARRIVAL IN CANADA (DD/MMM/YYYY)	DATE EDUCATIONAL PROGRAM OR WORK ASSIGNMENT BEGINS (DD/MMM/YYYY)	DATE EDUCATIONAL PROGRAM OR WORK ASSIGNMENT WILL END (DD/MMM/YYYY)	COVERAGE IS REQUIRED STARTING ON (DD/MMM/YYYY)

ARE YOU CURRENTLY ELIGIBLE FOR MANITOBA HEALTH INSURANCE?
❑ **No** ❑ **Yes** (If YES, you are not eligible for the MISHIP Inpatriate coverage)

IS YOUR SPOUSE CURRENTLY ELIGIBLE FOR MANITOBA HEALTH INSURANCE?
❑ **No** ❑ **Yes** (If YES, they are not eligible for the MISHIP Inpatriate coverage)

ARE YOU ELIGIBLE FOR OTHER HEALTH INSURANCE?
❑ **No** ❑ **Yes** (If YES, please provide name of other plan)
____

HAVE YOU BEEN COVERED BY THIS MISHIP PLAN BEFORE?
❑ **No** ❑ **Yes** (If YES, please provide your Mbr/EE ID)
Mbr/EE ID |____|____|____|____|____|____|____|____|____|

COVERAGE SELECTION *(Select One Only)*

❑ **SINGLE COVERAGE**

❑ **COUPLE COVERAGE** * *(Complete Dependent Information below)*

❑ **FAMILY COVERAGE** * *(Complete Dependent Information below)*

* Participants with an eligible Spouse and/or Children accompanying them to Manitoba must apply for Family Coverage immediately. If your eligible Spouse and/or Children are joining you later, please refer to the Rate Chart on Page 2 for instructions on calculating the appropriate premium.

Term (in months) ______________

Premium Payable $ ____________

(See Chart on Reverse for Term & Rate Information)

PREMIUM PAYMENT OPTIONS *(Select One Only)*

❑ **CHEQUE** – Please make cheque payable to Industrial Alliance.

❑ **CREDIT CARD PAYMENT** – I authorize Industrial Alliance to charge the credit card indicated below with the required premium.

Cardholder Name |____________________________________| ❑ **VISA** or ❑ **MasterCard**

Credit Card # |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Expiry Date |__|__|__| / |__|__|__|__| *(mmm/yyyy)*

LIST THE NAMES OF ALL DEPENDENTS TO BE INSURED

(If more space is required please attach separate list)

LAST NAME	FIRST NAME	RELATIONSHIP TO PARTICIPANT	DATE OF BIRTH (DD/MMM/YYYY)	GENDER	DATE OF ARRIVAL IN CANADA (DD/MMM/YYYY)
		❑ Spouse **OR** ❑ Common-Law Spouse		❑ Male ❑ Female	
		❑ Son ❑ Daughter		❑ Male ❑ Female	
		❑ Son ❑ Daughter		❑ Male ❑ Female	

AUTHORIZATION

I acknowledge that I have read the Notice on Privacy and Confidentiality on the back of this page concerning privacy practices and consent to the collection, use and disclosure of my and/or my dependent's personal information for the purposes specified.

I confirm that I am not eligible for coverage under the Manitoba Provincial Health Insurance Plan. I confirm that the information provided above is true and that any misrepresentation on this application regarding age, gender or eligibility may cause my coverage to be void.

I understand that the coverage contains limitations and exclusions.

I understand that coverage will not take effect until my properly completed application has been approved by Industrial Alliance and the premium has been paid.

Please sign **X** ____ **Date** ____________________

Signature of Participant * or Adult Responsible for Participant ***(Must always sign)***

** If the Participant is a minor, then the application must be reviewed and signed by a person who has responsibility for the Participant while in Canada. If you are signing on behalf of the Participant, please complete the information below.*

Name of Adult Responsible for Participant ***(Please print clearly)***
____

Day Phone Number
(______)______________________

ELIGIBILITY

To be eligible for coverage you must be a non-Canadian Participant or a non-Canadian member of the academic community under 70 years of age studying or working for a participating Educational Institution in the province of Manitoba.

A non-Canadian Spouse, under 70 years of age, or non-Canadian Dependent Children, under 25 years of age, of an eligible Participant are also eligible for coverage.

RATE CHART

Participants – Please note that you must enrol under the Manitoba Health Insurance Plan as soon as you are eligible to apply.

TERM OF COVERAGE *	SINGLE RATE PER PARTICIPANT	COUPLE RATE PER PARTICIPANT	FAMILY RATE PER PARTICIPANT
1 month	$ 65.00	$ 130.00	$ 175.00
2 months	110.00	220.00	300.00
3 months	135.00	270.00	350.00
4 months	200.00	400.00	500.00
5 months	240.00	480.00	600.00
6 months	270.00	540.00	700.00
7 months	320.00	640.00	850.00
8 months	370.00	740.00	1,000.00
9 months	420.00	840.00	1,150.00
10 months	470.00	940.00	1,300.00
11 months	520.00	1,040.00	1,450.00
12 months	570.00	1,140.00	1,600.00

* Note that premiums can not be adjusted or pro-rated. Each partial month of coverage must be rounded up to a full month. For example, if your Term of Coverage is for 3 weeks only, then you must pay the premium for 1 month of coverage. If your Term of Coverage is from January 15 to June 15, then you must pay the premium for 6 months of coverage.

If you arrive in Canada before your Spouse and/or Dependent Children arrive, you should pay the Single Rate premium for the term you are alone and then pay for the Couple or Family Rate for the time they will be in Canada. For example, if your Term of Coverage is for 6 months but your family arrives one month later, you should pay for 1 month at the Single Rate ($65.00) and then 5 months at the Family Rate ($600.00) for a total of $665.00. If you need assistance in determining the correct premium payable, please do not hesitate to contact one of our Customer Service Administrators at 1-800-266-5667.

Changes: Please notify us immediately if there is any change to your status and/or the status of your dependents.

Extension of coverage: If you need to extend your coverage, your request for an extension and your payment must be submitted before your current coverage expires.

UNDERWRITTEN BY

Please send your completed application together with your payment to:

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Toll Free Fax: 1-888-553-5433 (Credit Card payments only)

For inquiries, call us Toll Free at 1-800-266-5667 or by email at solutions@inalco.com

PLEASE READ CAREFULLY

NOTICE ON PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested pursuant to this application from you and which may be subsequently requested by us, from time to time, is required to process your application, and process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to any person you authorize or as authorized by law as well as those Industrial Alliance Insurance and Financial Services Inc. employees, its reinsurers, third party administrators, mandataries, agents or brokers of Industrial Alliance, plan sponsors and any agents or brokers of such sponsors or other market intermediaries who are responsible for (a) sponsoring a plan for you, (b) marketing and administration of products or services, (c) assessment of risk (underwriting) and (d) investigation of claims. Your file will be kept in Industrial Alliance's offices.

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at: 2165 West Broadway, P.O. Box 5900, Vancouver, BC, V6B 5H6, Attention: Manager, Administration, Special Markets Solutions.

Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found at our website www.inalco.com or alternatively, contact us at 1-800-266-5667 and request that a copy be faxed or mailed to you.

FOR OFFICE USE ONLY

Educational Institution #:	____________	Date Application Received:	__________________________
Date Application Processed:	__________________________	Date Fulfillment Sent:	__________________________
Processed by:	__________________________	Sent by:	__________________________