

## FOOTPRINTS RECRUITING INC. APPLICATION FOR INDIVIDUALS ON FOREIGN ASSIGNMENT

Personal Information					
Surname		Given Name		Initials	
Provincial Health Care No. (if applicable)					
Gender			Social Insurance Number:		
MALE <input type="checkbox"/>		FEMALE <input type="checkbox"/>			
Coverage Requested				Date of Birth (M/D/Y)	
SINGLE <input type="checkbox"/>	COUPLE <input type="checkbox"/>	COUPLE+1 <input type="checkbox"/>	COUPLE+2 <input type="checkbox"/>	COUPLE+3 <input type="checkbox"/>	COUPLE+4 <input type="checkbox"/>
Mailing Address					
City/Province			Postal Code		
Email Address (very Important)			Country of Foreign Assignment		
Business Phone Number			Home Country		
Date of Foreign Assignment		M/D/Y	Resident Phone Number	Fax Number	
Occupation			Annual Income and Currency		
Daily Duties					
Effective Date of Coverage		M/D/Y	Effective Date of Dependent Coverage (if applicable)		M/D/Y

Dependent Information (if applicable)						
Surname	Given Name	Date of Birth M/D/Y	Gender	Relationship to Insured	Provincial Gov't Health Care # (If applicable)	Country of Residence (If applicable)

Beneficiary Designation for Life Insurance and/or Accidental Death and Dismemberment Insured Through Hauteville Insurance Company				
Surname	Given Name	Relationship to Insured	Address	Percentage



Please check the appropriate box to indicate your selection of benefits.

Coverage	Benefit Summary
<b>Geographical Area of Coverage</b> <input type="checkbox"/> Worldwide <input type="checkbox"/> Restricted	<i>Canadian Currency Only</i> Worldwide Coverage Worldwide excluding North America
<b>Comprehensive Medical</b>	80% reimbursement for all eligible expenses \$1,000,000 maximum per lifetime.
<b>Annual Deductible per Insured Member</b>	<input type="checkbox"/> \$0.00 Deductible <input type="checkbox"/> \$200.00 Deductible <input type="checkbox"/> \$100.00 Deductible <input type="checkbox"/> \$500.00 Deductible
<b>OPTIONAL BENEFITS</b>	
<input type="checkbox"/> <b>Maternity Care Coverage Elected</b>	<i>Canadian Currency Only</i> Overall maximum of 80% of the eligible expense, subject to a maximum of \$250,000. Coverage will not apply where the expected date of childbirth is less than ten (10) months from the Insured Person's original effective date of this option.
<input type="checkbox"/> <b>Accidental Death and Dismemberment</b>	<i>Offered in US Currency Only</i> May be purchased in units of \$1,000 to a maximum of \$500,000 Sum Insured Elected: US\$
<input type="checkbox"/> <b>Life Insurance</b>	<i>Offered in US Currency Only.</i> May be purchased in units of \$10,000 to a Maximum of \$500,000 Sum Insured Elected: US\$
<input type="checkbox"/> <b>Long Term Disability</b>	<i>Offered in US Currency Only</i> Monthly Benefit is based on 70% of Monthly Earnings or a lesser amount if elected. The Elimination Period is 90-Days for any disability resulting from Illness or Injury.

<b>Billing Information</b>	
<input type="checkbox"/> Insured Member <input type="checkbox"/> Corporate Billing as Indicated Below	Period for which application is made and Premium to be Paid (minimum 3 months to a maximum of 12 months)
Name of Contact Person:	___ Months
Title of Contact person:	
Email Address:	
Corporate Name:	
Mailing Address:	

**Protecting Your Personal information**

We recognize and respect your right to privacy. Therefore, when you apply for coverage, we establish a confidential file that is kept in our office. We limit access to information in your file to authorized persons who require the information to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefits plan.

**Authorizations and Declarations**

- I hereby apply for coverage under the group benefits plan.
- I authorize:
  - Any healthcare provider, my plan administrator, other insurance companies, or benefits providers working with this plan to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits plan.
- If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I certify that the information given is true, correct and complete to the best of my knowledge.

*Applicant's Signature:*

*Date:*



**PAYMENT AUTHORIZATION AND SIGNATURE**

**Please select your method of payment:**

Visa

MasterCard

Credit Card Number:

Name as it Appears on Credit Card: \_\_\_\_\_

Credit Card Expiry Date: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

**Authorization**

I authorize Norfolk Mobility Benefits Inc., to charge my credit card for the total Premium as communicated.

Signature of Card Holder: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

## Health Questionnaire – Primary Insured

Name of Employee			Telephone ( )	Occupation	Annual Salary \$
Surname	First Name	Middle Initial			
Address of Employee (number, street)					Date of Birth (dd./mm/yy)
Street	Apt.	City	Province	Postal Code	

**INCOMPLETE FORMS WILL BE RETURNED**

<b>To be completed by the Employee – Statement of Health – Answer Every Question – Give Details</b>
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1. Height \_\_\_\_\_ m \_\_\_\_\_ ft      b) Weight \_\_\_\_\_ kg \_\_\_\_\_ lbs.

**Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:**

<p>2 a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) asthma, chronic cough, shortness of breath, or convulsions      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c) high blood pressure? If yes provide BP Readings for the past 12-months      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>e) ulcer, liver disorder, colitis, chronic diarrhea, hepatitis or any digestive disorder?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g) cancer, tumor, leukemia, enlarged glands or lymph nodes?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h) diabetes, sugar in urine or thyroid disorder?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>i) urine, kidney or bladder disorder?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>j) anemia, bleeding or blood disorder?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>k) difficulty with eyes or ears?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>m) a positive HIV (Human Immune Deficiency Syndrome) test?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>5 Do you have an annual checkup      <input type="checkbox"/> No <input type="checkbox"/> Yes          If “Yes” provide results: _____          If “No” provide date and results of last check up.          Date: _____ Results: _____</p> <p><b>In the past 5 years have you:</b></p> <p>6 a) except for an annual check up, consulted a Doctor or other health practitioner, submitted to an ECG, blood tests, X – rays or other tests, had surgery or been treated in a hospital?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) received or applied for disability benefits for 3 months or longer?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c) had a urinary tract infection or any sexually transmitted disease?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>Within the past 12 months, have:</b></p> <p>7 a) your duties been modified due to health reasons?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) you been off work for more than 5 consecutive days due to illness or injury?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c) you used tobacco products?      <input type="checkbox"/> No <input type="checkbox"/> Yes          If “Yes”, indicate the number per day _____</p> <p>8 Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>9 Are you presently under medical treatment by diet, Medicine, or other means?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>10 Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>11 a) For women: are you pregnant?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) Have you ever had any complications of pregnancy?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>12 In the past 12-months have you experienced any symptoms that you have not yet sought medical attention for ?      <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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Name of Applicant: \_\_\_\_\_

**For each "Yes" answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.**

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

**Authorization**

I certify that the above statements and those on any attached sheet are true and complete. I authorize Norfolk Mobility Benefits Inc., and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for Norfolk Mobility Benefits Inc, to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy of this authorization is as valid as the original.

Date: \_\_\_\_\_

Signature of Primary Insured \_\_\_\_\_  
(Required in all instances)

**You should keep a copy of this Health Questionnaire for your records.**