UHIP© application form

Cowan

Clear

Policy number
150150

Please check one of the following:

☐ Member only application ☐ Member and dependant application ☐ Dependant only application

Please PRINT clearly.

1 Member information

Please advise the UHIP office at your University immediately of any changes in your status. (This includes new address, phone number, addition of dependants, etc.)

University name			University ID number
Last name		First name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Email address	
Canadian address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Coverage start date (dd-mm-yyyy)		Coverage end date (dd-mm-yyyy)	

2 Dependant information

If you have or will have eligible dependants living with you in Canada, they **must** be covered by UHIP©. **Complete this section if you have dependants that need to be enrolled in UHIP coverage.**

Spouse last name		Spouse first name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Coverage start date (dd-mm-yyyy)	Coverage end date (dd-mm-yyyy)

☐ I confirm that my common-law or same-sex relationship has existed for at least 12 months.

Child last name		Child first name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Coverage start date (dd-mm-yyyy)	Coverage end date (dd-mm-yyyy)

Child last name		Child first name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Coverage start date (dd-mm-yyyy)	Coverage end date (dd-mm-yyyy)

Child last name		Child first name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Coverage start date (dd-mm-yyyy)	Coverage end date (dd-mm-yyyy)

Child last name		Child first name	Date arrived in Canada (dd-mm-yyyy)
Date of birth (dd-mm-yyyy)	☐ Female ☐ Male ☐ Non-binary ☐ Undisclosed	Coverage start date (dd-mm-yyyy)	Coverage end date (dd-mm-yyyy)

3 Member authorization and signature

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I authorize Cowan Insurance Ltd, Manulife (the insurer), their agents and service providers and the UHIP© plan administrator to collect, use and disclose relevant information about me and my dependants in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage ("Purposes"). The insurers are committed to keeping this information confidential.

I understand that UHIP© coverage is mandatory and I am responsible for enrolling my eligible dependants within 30 days of their arrival date in Canada. Otherwise, I will have to pay a $500 late application fee for my dependants, and premiums retroactive to their date of arrival in Canada. I confirm that I am authorized by my dependants to consent to this authorization, on their behalf as if they were signing it themselves, and to disclose and receive their information, for the Purposes.

I further understand that the coverage I have indicated on this form will be assumed to hold true for the duration of my studies or employment at the university named above, unless I communicate to the university UHIP Plan Administrator any change to my personal situation that would require adjustment of my premium (e.g. addition of dependants).

By signing below, I release the University named above, Cowan Insurance Ltd. and Manulife from any responsibility for any undeclared dependants and for health care costs incurred by me or any of my dependants that are not eligible for reimbursement by UHIP©. I understand that the University named above, Cowan Insurance Ltd. and Manulife will accept no financial liability for any such costs.

A photocopy or electronic version of this authorization is as valid as the original and will remain in effect for the duration of my coverage under the UHIP© Plan.

Member signature X	Date (dd-mm-yyyy)

Please return your completed form to your university UHIP© Plan Administrator.

4 Temporary proof of coverage

Shaded area to be completed by university UHIP® plan administrator.

Standard enrolment		
Effective date of coverage (dd-mm-yyyy)	Coverage termination date (dd-mm-yyyy)	Premium paid/owing $
Expiry date of temporary proof of coverage (dd-mm-yyyy)	Name of person issuing temporary proof of coverage	Signature of person issuing temporary proof of coverage X
Late entrant/dependant enrolment		
Date from which retroactive premium is due (dd-mm-yyyy	Late application fee of $500 (dependant enrolment **only**)	**$500.00**
Date validated (dd-mm-yyyy)	Retroactive premium (premium rates in effect at time of application)	$
University stamp	Premiums for remaining period of current academic year	$
Form not valid unless stamped	**Total premium due**	**$**

5 Respecting your privacy

We know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

I acknowledge that more detailed information concerning how and why Manulife and/or Cowan collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or www.cowangroup.ca/home/privacy-policy/.