Standard Program
Application

Please complete all information requested below, sign and return by mail to AFBS.

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 1.855.934.2355
or 416.934.2355
E-MAIL: admin@writerscoalition.ca
WEB: writerscoalition.ca

WRITERS' COALITION PROGRAM

IMPORTANT NOTE FOR QUEBEC RESIDENTS: Please confirm you have RAMQ coverage before applying. This plan supplements RAMQ and does not replace it.

Fields marked with an asterisk (*) are required.

SECTION 1 – Information About You *(please print)*

Reset Form

Legal Name (Last, First, Middle Initial)*	Lived/Affirmed/Chosen Name	Date of Birth*	Gender at Birth*
		DD MM YYYY	☐ M ☐ F

Street Address*	City*	Province*	Postal Code*

Telephone Number (Day)*	Telephone Number (Alternative)	E-Mail Address*

Your Arts Organization or Group	Date of Membership	Occupation*
	DD MM YYYY	

Your e-mail address is important to us. AFBS values your privacy and we do not sell or rent out contact information relevant to the Writers' Coalition Program. You may choose to opt-out of receiving commercial electronic messages at anytime.

Please check this box to provide your express written consent to receiving commercial electronic messages from us. ☐

SECTION 2 – Information About Your Dependants *(please print)*

PLEASE ONLY COMPLETE IF YOU ARE APPLYING TO INSURE YOUR DEPENDANTS

	Last Name	First Name	Gender (M/F)	Date of Birth	College/University For dependants between ages 18 and 26
Spouse/ Partner				DD MM YYYY	
Child				DD MM YYYY	☐
Child				DD MM YYYY	☐
Child				DD MM YYYY	☐

Please check in [X] under College/University if your eligible dependant is over 18 years of age and in school full-time or is incapable of self-sustaining employment because of a handicap or disability (Physician letter required).

SECTION 3 – Coordination of Benefits *(please print)*

Are you, your spouse/partner or dependant child(ren) insured under any other program that reimburses health, prescription drug or dental expenses?

☐ NO If 'NO' please proceed to Section 4

☐ YES If 'YES', effective date DD MM YYYY ☐ My spouse only ☐ All dependants ☐ Myself only

Please indicate: ☐ Extended Health Care & Dental Care ☐ Extended Health Care only ☐ Dental Care only

Name of insurer _____ Policy/Contract # _____ Certificate # _____

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SECTION 4 – Premium Calculation and Payment Options

Monthly Premium Rates:

IMPORTANT:
If you are a resident of Quebec, and are NOT insured with RAMQ, you are ineligible for coverage. Please contact AFBS.

Premium rates will change and are based on your age at the time of each renewal.

Rates with Dental (Excluding QC)			
AGE	**SINGLE**	**COUPLE**	**FAMILY**
Under 65	$ 80.81	$141.78	$198.33
Age 65 and over	$130.50	$233.80	$316.95

Quebec rates with Dental			
AGE	**SINGLE**	**COUPLE**	**FAMILY**
Under 65	$ 56.68	$ 97.69	$139.26
Age 65 and over	$105.54	$188.04	$254.55

Rates without Dental (Excluding QC)			
AGE	**SINGLE**	**COUPLE**	**FAMILY**
Under 65	$ 63.13	$108.30	$141.34
Age 65 and over	$124.26	$222.36	$297.19

Quebec rates without Dental			
AGE	**SINGLE**	**COUPLE**	**FAMILY**
Under 65	$ 39.00	$ 64.20	$ 82.27
Age 65 and over	$ 99.30	$176.60	$234.79

I am applying for: Single coverage ☐ Couple coverage ☐ Family coverage ☐ Monthly Premium Cost: $ _____

☐ I/We declare that all persons included in this application:
a) are residing in Canada at the time of application;
b) are artists, work in or are affiliated with the arts, or belong to an arts organization or group; and
c) have valid coverage under a provincial health insurance plan.

Quebec Residents Only: I declare that I benefit from coverage under the RAMQ Public Prescription Drug Insurance Plan, or another insurance plan that covers prescription drug, and that I am joining a supplemental RAMQ plan that provides no drug coverage.

Payment Options:

☐ **Pay In Full (Annual Payment)**

You may pay the full amount due: $ _____ (Monthly Amount Due x 12)

☐ By cheque (please make your cheque payable to AFBS) ☐ Visa ☐ MasterCard

Cardholder's Name	Card Number	Expiry Date MM YYYY

Cardholder's Signature (Required)

☐ **Pay Monthly**

I will pay the monthly amount due of $ _____ by pre-authorized debit. A cheque for the first month's amount due, made payable to AFBS, plus a 'VOID' cheque or a direct deposit form from your financial institution must accompany this Application Form. Forms that include financial institution information must be mailed to AFBS. Further payments will be withdrawn from your account on the 15th of each month or the next business day. Please continue to the next page.

AFBS

SECTION 4 – Premium Calculation and Payment Options (continued) (please read carefully before signing)

PLEASE ATTACH A PERSONALIZED 'VOID' CHEQUE OR A DIRECT DEPOSIT FORM FROM YOUR FINANCIAL INSTITUTION HERE.
Forms that include financial institution information must be mailed to AFBS, 1000 Yonge Street, Toronto, ON M4W 2K2. Do not email this form.

Attach a VOID Cheque
or Direct Deposit Form Here

Withdrawal Agreement

☐ Fixed ☑ Variable

Recourse

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 **payments.ca**.

Authorization (MUST BE SIGNED).

I/we, as the Account Holder(s), authorize Actra Fraternal Benefit Society (AFBS) and the financial institution indicated on the attached 'VOID' cheque or direct deposit form, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and service charges for insurance under my policy. The PAD amount will be debited from the account indicated on the attached 'VOID' cheque or direct deposit form on the 15th of each month or on the next business day. I/we agree to notify AFBS in writing, by mail, if there is any change to the financial institution information provided on the attached document.

I/we waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/we agree that AFBS will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in service charges, or the increase to the PAD amount is a result of my/our request.

I/we may cancel this PAD Agreement at any time, subject to providing notice to AFBS at the address provided above. This notification must be received at least thirty (30) days before the next debit is scheduled. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting payments.ca.

I/we understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under my policy, provided that payment is received when due and is made in accordance with the terms of your policy.

This PAD Agreement only applies to the method of payment. I/we understand that completing this PAD Agreement does not mean that the application for insurance coverage has been approved.

Signature (Required)	Date DD MM YYYY
Signature of all other Account Holders (if a required signatory to this account)	Date DD MM YYYY

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SECTION 5 – Terms and Conditions

I/we certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that the purpose of providing this information to AFBS is to assist with the accurate administration of my benefits as well as those of any insured dependants. I further understand that AFBS is providing this information to ClaimSecure, or successor provider of electronic claims processing, to assist with the adjudication of online claim submissions and claims processing, Dialogue with respect to the Member and Family Assistance Program, Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group), the providers of the Travel Emergency Medical Benefit; and its actuaries and reinsurers and agree to this use of the information provided.

I understand that insurance will take effect on the first of the month following the date AFBS receives my properly completed application, the first month's premium and subject to approval by AFBS.

I authorize AFBS to provide me with confirmation of premium paid under this private health services plan annually at the conclusion of each calendar year.

I agree that a photocopy or electronic version shall be as valid as the original.

Signature of Applicant (Required)	Date DD MM YYYY

If you are paying by credit card or pre-authorized debit, please ensure that you have signed your payment option choice in Section 4. Your signature is required in Section 5.

Please send your **COMPLETED** and **SIGNED** form to: **AFBS**, 1000 Yonge Street, Toronto, ON M4W 2K2

IMPORTANT INFORMATION

Seniors' Premium Surcharge: (excluding residents of QC)

The premium rates for individuals age 65 and over take into account that most seniors currently have access to their province's provincial drug program. From age 65 onward, AFBS usually assumes a second payor position. This means that the cost of eligible prescriptions is paid first by your provincial program. Any eligible amount which is not covered by your provincial drug program may be submitted to AFBS.

If you are ineligible for coverage under your provincial drug program, AFBS will provide equivalent benefits. A premium surcharge of 10% is included when AFBS is the first payor.

Individuals Residing in Quebec:

This is a Supplemental Plan in Quebec. Members residing in Quebec must be enrolled in the RAMQ Public Prescription Drug Insurance Plan. RAMQ is your sole prescription drug provider unless you are insured elsewhere. AFBS does not provide prescription drug coverage in Quebec under the Writers' Coalition Program.

Protecting Your Privacy:

Protecting your privacy is of the utmost importance to AFBS. It is fundamental to the way we conduct business. It continues to be our highest priority when dealing with you. AFBS collects personal information about you and your family as required to accurately manage and administer the eligible insurance benefits. In turn, AFBS provides information about you to our insurance partners as indicated in Section 5. These organizations ensure the highest level of confidentiality because of the nature of the services they provide as well as their contractual obligations with AFBS.

Any personal information held by AFBS or any other AFBS insurance partner is kept strictly confidential and is only available to you or your representative, as designated by you.

The AFBS Benefits department is committed to resolving any privacy issue with you as quickly as possible. If there is a privacy or confidentiality issue that is not resolved to your satisfaction, please provide written notice to the Privacy Officer at privacy@afbs.ca.

AFBS