

FORM 10AE Enrolment Form

Please complete all information requested below, sign and return to:
AFBS, 1000 Yonge Street, Toronto, Ontario M4W 2K2

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416-967-6600 1-800-387-8897
FAX: 416-967-4744 1-888-804-8929
E-MAIL: benefits@afbs.ca

AFBS WEST: 320 -1155 Pender Street West
Vancouver, BC V6E 2P4
PHONE: 604-801-6550 1-866-801-6550
FAX: 604-801-6580
E-MAIL: afbswest@afbs.ca



SECTION 1 – Information About You (please print)

[Reset Form](#)

Name (Last, First, Middle Initial)		Date of Birth DD MM YYYY	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Insurance Number
Street Address		City	Province	Postal Code
Telephone Number (Day)	Telephone Number (Alternative)	E-Mail Address*		
Participating Organization		Occupation	Date of Membership/Employment DD MM YYYY	

Confirmation of **Provincial Drug Plan** coverage (for applicants age 65 and over only). YES NO
Please read Seniors' Premium Surcharge if you have checked 'No' (Section 4).

*Your e-mail address is important to us. AFBS values your privacy and we do not sell or rent out contact information about our membership. From time to time, you may receive e-mails from us about new programs and other information relevant to the Arts & Entertainment Plan™. You may choose to opt-out of our e-mail mail list at the time you receive an e-mail from us, or now by checking this box.

SECTION 2 – Information About Your Dependants (please print)

PLEASE ONLY COMPLETE IF YOU ARE APPLYING TO INSURE YOUR DEPENDANTS

If you reside in Québec please read the Special Note - Requirement to provide dependant coverage

	Last Name	First Name	Gender (M/F)	Date of Birth DD MM YYYY	College/University For dependants between ages 18 and 26
Spouse/ Partner				DD MM YYYY	
Child				DD MM YYYY	<input type="checkbox"/>
Child				DD MM YYYY	<input type="checkbox"/>
Child				DD MM YYYY	<input type="checkbox"/>

Please check in under College/University if your eligible dependant is over 18 years of age and in school or is incapable of self-sustaining employment because of a handicap or disability.

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?

YES If 'YES', effective date My spouse only All dependants Myself only

NO If 'NO' please proceed to Section 4

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

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

Underwritten by:

Actra Fraternal Benefit Society: 1000 Yonge Street, Toronto, Ontario M4W 2K2

Telephone: (416) 967-6600 / Toll Free: 1-800-387-8897 Fax: (416) 967-4744 / Toll Free Fax: 1-888-804-8929

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SECTION 4 – Premium Calculation and Payment Options

I am applying for: Single coverage Couple coverage Family coverage

Monthly Premium Rates:

AGE	SINGLE	COUPLE	FAMILY
UP TO AGE 44	\$112.83	\$204.93	\$294.93
AGE 45 - 49	\$121.83	\$222.93	\$315.93
AGE 50 - 54	\$130.83	\$240.93	\$339.93
AGE 55 - 59	\$141.83	\$260.93	\$365.93
AGE 60 - 64	\$133.83	\$245.93	\$340.93
AGE 65 - 69	\$125.62	\$228.72	\$315.72
AGE 70 - 75	\$113.50	\$207.60	\$284.60

Premium Calculation Instructions:

1. Determine your current monthly premium cost;
2. Québec residents under age 65 please read Requirement to Provide Dependant Coverage;
3. Senior members who are not enrolled in your provincial drug plan please read Seniors' Premium Surcharge;
4. Calculate your monthly premium;
5. Québec, Ontario and Manitoba residents calculate required retail sales tax;
6. Complete your payment option choice;
7. Date and sign your Enrolment Form and forward to AFBS.

Premium rates will change and are based on your current age at each annual renewal.

Monthly Premium Calculation: Monthly Premium Cost: \$ _____

Are you a resident of Québec and under age 65? YES NO

If 'YES' calculate 10% premium surcharge: \$ _____ (Monthly Premium Cost X .10)

For Applicants Age 65 or Older:

Indicate if you are you age 65 or older and insured through your province's provincial drug plan? YES NO

If 'NO' calculate 10% premium surcharge: \$ _____ (Monthly Premium Cost X .10)

Monthly Premium Cost Sub Total: \$ _____

Premium Tax:

Are you a resident of Québec? YES NO

If "YES" calculate retail sales tax 9%: \$ _____ (Monthly Premium Cost Sub Total X .09)

Are you a resident of Ontario? YES NO

If "YES" calculate retail sales tax 8%: \$ _____ (Monthly Premium Cost Sub Total X .08)

Are you a resident of Manitoba? YES NO

If "YES", please check age:

Under 65 (Add \$0.17) 65-69 (Add \$0.09) 70-75 (Add \$0.08): \$ _____ (Monthly Premium Cost Sub Total X .07 for Group Term Life and AD&D Insurance **ONLY**)

Monthly Amount Due: \$ _____

Payment Options:

You may pay the full amount due by cheque, VISA or MasterCard **or** choose the monthly pre-authorized debit (PAD) payment option.

I will be paying the full amount due: \$ _____ (Monthly Amount Due x 12)

By cheque (please make your cheque payable to **AFBS**) By Credit Card Visa MasterCard

Cardholder's Name

Card Number

Expiry Date

MM YYYY

Cardholder's Signature (Required)

I will be paying 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 must accompany this Enrolment Form. Further payments will be withdrawn from your account on the 14th of each month or the next business day. Please continue to the next page.

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

Pre-authorized debit (PAD) details:

Please debit my bank account for the amount indicated. I have attached a 'void' cheque and understand that this amount will be debited from my account on the 14th day of each month or the next business day.

I, the Payor, authorize AFBS to debit the bank account identified on my 'void' cheque for the payment of the Arts & Entertainment Plan™ insurance benefits for which I have made application, including provincial retail sales tax as may be required, in order to keep my insurance benefits in place.

I, the Payor, may revoke this authorization at any time, subject to providing 30 days written notice to AFBS. I understand that revoking this authority may affect my insurance benefits under the Arts & Entertainment Plan™. (To obtain a sample cancellation form, or for more information on your rights to cancel a PAD agreement, contact your financial institution or visit www.cdnnpay.ca.)

I, the Payor, have certain recourse rights if a debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. (To obtain information on your recourse rights, contact your financial institution or visit www.cdnnpay.ca.)

Name of Accountholder (please print)	Signature of Accountholder (required)	Date DD MM YYYY
Name of Joint Accountholder (please print)	Signature of Joint Accountholder (required)	Date DD MM YYYY

THE PAYMENT OPTION AND INFORMATION PROVIDED IN THIS SUB-SECTION 'PAYMENT OPTIONS' IS VALID FOR ONE YEAR ONLY. NOTIFICATION WILL BE MAILED TO THE ADDRESS ON FILE WITH AFBS IN ADVANCE OF EACH ANNUAL RENEWAL. CONTINUATION OF COVERAGE UNDER THE ARTS & ENTERTAINMENT PLAN™ WILL BE DEPENDENT ON THE RE-CONFIRMATION OF YOUR PAYMENT OPTION AND REMITTANCE OF THE APPROPRIATE PREMIUM DUE AT THAT TIME.

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/we 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/we further understand that AFBS is providing this information to ClaimSecure, or successor provider of electronic claims processing, to assist with the adjudication of on-line claims submissions and claims processing and agree to this use of the information provided.

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

I authorize AFBS to use my social insurance number for identification purposes only and to provide me with confirmation of premium paid under this private health services plan annually at the conclusion of each calendar year.

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

Signature of Applicant	Date DD MM YYYY
Signature of Spouse (required only when insurance protection has been requested in Section 2)	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

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IMPORTANT INFORMATION

Seniors' Premium Surcharge:

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.

Québec Residents - Special Note - Requirement to Provide Dependant Coverage:

The Québec government requires that all residents have prescription drug coverage through a private insurance program, such as the Arts & Entertainment Plan™, or Régis de L'Assurance Maladie du Québec (RAMQ). Your dependants do not qualify for coverage under RAMQ's basic prescription insurance program when you participate in a private insurance program.

If you have eligible dependants who are under age 65 you must insure them through the Arts & Entertainment Plan™ when you are enrolling (or the date on which you acquire each new dependant, if later) if they are not already covered under another group insurance program.

When providing protection to residents of Québec, AFBS must comply with the RAMQ formulary and deductibles the impact of which is a 10% premium surcharge.

When you complete your income tax, you will be asked to confirm that you have complied with the provisions of the Québec legislation.

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 ClaimSecure, who provide the on-line claims service for adjudication and reimbursement of eligible prescription drug and dental expenses. ClaimSecure ensures 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 AFBS.

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