THE
ARTS &
ENTERTAINMENT PLAN™

# FORM 10A&E
# Enrolment Form

**Please complete all information requested below, sign and return to:**

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

## *SECTION 1* - Information About You (please print)

| NAME (Last, First, Middle Initial) | DATE OF BIRTH DD MM YYYY | GENDER ☐ M ☐ F | SOCIAL INSURANCE NUMBER |
|---|---|---|---|
| STREET ADDRESS | CITY | PROVINCE | POSTAL CODE |

| TELEPHONE NUMBER (DAY) | TELEPHONE NUMBER (ALTERNATIVE) | E-MAIL ADDRESS * | OCCUPATION |
|---|---|---|---|
| PARTICIPATING ORGANIZATION | | | 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'.

*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 | 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 ☒ under College/University if your eligible dependant is over 18 years of age and 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 DD MM YYYY ☐ 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
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## *SECTION 4* - Premium Calculation and Payment Option

I am applying for: Single coverage ☐ Couple coverage ☐ Family coverage ☐

**Monthly Premium Rates:**

| AGE | SINGLE | COUPLE | FAMILY |
|---|---|---|---|
| Up to Age 45 | $109.00 | $202.00 | $293.00 |
| 46-50 | $119.00 | $221.00 | $317.00 |
| 51-55 | $129.00 | $239.00 | $342.00 |
| 56-60 | $141.00 | $262.00 | $373.00 |
| 61-65 | $134.00 | $249.00 | $349.00 |
| 66-70 | $130.00 | $240.00 | $333.00 |
| 71-75 | $117.00 | $217.00 | $300.00 |

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 and Ontario 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)

Are you age 65 or older and insured through your province's Provincial Drug Plan? (Please answer only if you are 65 or older)

Yes ☐ No ☐ If 'No' calculate 10% premium surcharge: $__________ (Monthly Premium Cost X .10)

**Monthly Premium Cost Sub Total: $**__________

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)

**Monthly Payment Due: $**__________

**Payment Options:**

You may pay the annual premium due by cheque, VISA or MasterCard or choose the monthly pre-authorized payment option.

☐ I will be paying the payment due annually: $__________ (Monthly Payment Due X 12)

☐ By cheque (please make your cheque payable to **Actra Fraternal Benefit Society**)

☐ By Credit Card ☐ Visa ☐ MasterCard

| CARDHOLDER'S NAME | CARD NUMBER | EXPIRY DATE MM YYYY |
|---|---|---|
| | | |

CARDHOLDER'S SIGNATURE (required)

☐ I will be paying the monthly payment due of $__________ by pre-authorized cheque. A cheque for the first month's premium made payable to **Actra Fraternal Benefit Society** plus a 'void' cheque must accompany this Enrolment Form. 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.

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*SECTION 4* - **Premium Calculation and Payment Option (continued)** (please read carefully before signing)

**Pre-authorization Debit (PAD) Details:**

Please debit my bank account for the amount indicated. I have attached a 'void' cheque and understand that this debit will be processed from my account on the 15th day of each month or the next business day.

I, the Payor, authorize Actra Fraternal Benefit Society 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 Actra Fraternal Benefit Society. 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 my rights to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.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.cdnpay.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 BENEFIT YEAR ANNIVERSARY. 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 Actra Fraternal Benefit Society is to assist with the accurate administration of my prescription drug, Extended Health Care and Dental Care benefits as well as those of any insured dependants. I/we further understand that Actra Fraternal Benefit Society 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 Actra Fraternal Benefit Society 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:
**Actra Fraternal Benefit Society,** 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 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 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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