



# Public Service Health Care Plan (PSHCP) for Veterans Affairs Canada Positive Enrolment & Pre-authorized Debit Form

Plan number
Certificate number

## Instructions

- Any incomplete or illegible form will be returned to you by mail for re-submission.
- Complete all sections of the form. PRINT clearly in ink, sign, date and mail it to:

Canada Life  
 BAS DG1227  
 PO Box 6000 Stn Main  
 Winnipeg, MB R3C 3A5

Questions? Visit [canadalife.com/pshcp](http://canadalife.com/pshcp) or call us at 1-855-415-4414, Monday to Friday 8 am to 5 pm, your local time.

- I am completing my positive enrolment for the first time with Canada Life.
- I have already done my positive enrolment and need to make a change.

## 1 Your contact information

Last name		First name	
Date of birth (mmm-dd-yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer	
Mailing address (street number and name, and/or P.O. Box)			Apartment
City	Province/Territory/State	Postal/Zip code	Country
Current country of residence for Comprehensive Members		The current country of residence is where you are currently residing, working, deployed or posted to. This can differ from your mailing address.	
Canadian province or territory for health care		Province or territory where you are covered for provincial or territorial health coverage when you are in Canada.	

## 2 Preferred method of communication

**How do you want to be contacted?**

Please select only one. If both are selected, we will consider that your preferred method of communication is email.

Email (provide email address)

Paper (communications will be sent to the mailing address you provided in section 1)

## 3 Your coordination of benefits information

Apart from the PSHCP, do you have other health care coverage as a Member?  Yes  No If yes, please complete the questions below.

What benefits are you covered for under your other plan (select all that apply)?  Health  Drugs  Vision

Is your other coverage with Canada Life?  Yes  No If yes, plan number:  Member ID:

Are you a retiree under your other plan?  Yes  No If no, which plan started first?  The PSHCP  The other plan

## 4 Information about your eligible spouse or common-law partner

Reason for change:  Add  Change  Remove Effective date (mmm-dd-yyyy)

Last name		First name	
Date of birth (mmm-dd-yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer	

Is your spouse or common-law partner covered under another group health care plan?  Yes  No If yes, please complete the questions below.

What benefits are they covered for (select all that apply)?  Health  Drugs  Vision

Does your spouse or common-law partner have their own coverage under the PSHCP?  Yes  No

If yes, provide your spouse or common-law partner's PSHCP certificate number:

If no, is the other coverage with Canada Life?  Yes  No If yes, plan number:  Member ID:

## 5 Information about your eligible dependant children

### Dependant 1

Reason for change:  Add  Change  Remove Effective date (mmm-dd-yyyy) 

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer

- Dependant child (under age 21)  
 Child with a disability (age 21+)  
 Full-time student (if between ages 21-25) If full-time student:

Institution name   
Program name  Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan?  Yes  No If yes, please complete the questions below:What benefits are they covered for (select all that apply)?  Health  Drugs  VisionIs your dependant's other coverage with another parent or guardian?  Yes  No If yes, provide the name and date of birth of the other parent or guardian:Last name  First name  Date of birth (mmm-dd-yyyy) Is the other coverage with Canada Life?  Yes  No If yes, plan number:  Member ID: 

### Dependant 2

Reason for change:  Add  Change  Remove Effective date (mmm-dd-yyyy) 

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer

- Dependant child (under age 21)  
 Child with a disability (age 21+)  
 Full-time student (if between ages 21-25) If full-time student:

Institution name   
Program name  Program end date (mmm-dd-yyyy)

Is your dependant covered as a member or dependant under another group health care plan?  Yes  No If yes, please complete the questions below:What benefits are they covered for (select all that apply)?  Health  Drugs  VisionIs your dependant's other coverage with another parent or guardian?  Yes  No If yes, provide the name and date of birth of the other parent or guardian:Last name  First name  Date of birth (mmm-dd-yyyy) Is the other coverage with Canada Life?  Yes  No If yes, plan number:  Member ID:

**5 Information about your eligible dependant children (continued)**

If you need to add more than four dependants, use a photocopy of this form.

**Dependant 3** Reason for change:  Add  Change  Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer

- Dependant child (under age 21)
- Child with a disability (age 21+)
- Full-time student (if between ages 21-25) If full-time student:

Institution name	<input type="text"/>	
Program name	<input type="text"/>	Program end date (mmm-dd-yyyy) <input type="text"/>

Is your dependant covered as a member or dependant under another group health care plan?  Yes  No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)?  Health  Drugs  Vision

Is your dependant's other coverage with another parent or guardian?  Yes  No If yes, provide the name and date of birth of the other parent or guardian:

Last name	First name	Date of birth (mmm-dd-yyyy)
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Is the other coverage with Canada Life? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, plan number: <input type="text"/>	Member ID: <input type="text"/>
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**Dependant 4** Reason for change:  Add  Change  Remove Effective date (mmm-dd-yyyy)

Last name	First name
Date of birth (mmm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer

- Dependant child (under age 21)
- Child with a disability (age 21+)
- Full-time student (if between ages 21-25) If full-time student:

Institution name	<input type="text"/>	
Program name	<input type="text"/>	Program end date (mmm-dd-yyyy) <input type="text"/>

Is your dependant covered as a member or dependant under another group health care plan?  Yes  No If yes, please complete the questions below:

What benefits are they covered for (select all that apply)?  Health  Drugs  Vision

Is your dependant's other coverage with another parent or guardian?  Yes  No If yes, provide the name and date of birth of the other parent or guardian:

Last name	First name	Date of birth (mmm-dd-yyyy)
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Is the other coverage with Canada Life? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, plan number: <input type="text"/>	Member ID: <input type="text"/>
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## 6 Authorization and declaration

- The Plan Sponsor is the Government of Canada
- The Federal Public Service Health Care Plan (PSHCP) Administration Authority is the corporation charged with the administration of the PSHCP
- The contracted Plan Administrator is The Canada Life Assurance Company (Canada Life)
- Personal information, for the purposes of this Consent, means the personal information described in the [PSHCP Privacy Statement](#)

The Government of Canada collects, handles, and retains personal Information for the purpose of administering the PSHCP in accordance with Canada's [Privacy Act](#). The [PSHCP Privacy Statement](#) has been developed to comply with the [Privacy Act](#).

As the contracted Plan Administrator, Canada Life has agreed to comply with the [Privacy Act](#). Canada Life is subject to other applicable privacy legislation in jurisdictions where it operates. Canada Life posts its [Privacy Guidelines](#) on its website. Where there is a difference between the [Privacy Act](#) and this other legislation, Canada Life will apply the most stringent requirements. Your personal information and that of any eligible dependants will be maintained securely and in a confidential manner. Your personal information is used to administer your coverage and as otherwise authorized or required by law.

Access to your personal information is limited to persons who require it to perform their duties, and to persons you have granted access. Your personal information may be disclosed to health care providers, other insurance or reinsurance companies, claims processing providers, technology suppliers, and other service providers referred to in the [PSHCP Privacy Statement](#) or Canada Life's [Privacy Guidelines](#). Your personal information may also have to be disclosed to public and government authorities under applicable law in Canada or elsewhere. Your personal information may be collected or communicated outside of Canada or outside your province of residence as part of day-to-day business.

For access to the [Privacy Act & PSHCP Privacy Statement](#), visit [canadalife.com/pshcp](http://canadalife.com/pshcp).

### Declarations

1. I have read and I understand the [PSHCP Privacy Statement](#) and Canada Life's [Privacy Guidelines](#).
2. I agree the Plan Sponsor, the Federal PSHCP Administration Authority, Canada Life and its service providers, and other entities referred to above may collect, use and disclose personal information about me and my dependants for the administration of the PSHCP, including the adjudication of claims. This includes the use and disclosure with other persons and organizations who have, or require, the information for these purposes.
3. I confirm my dependants over 18 years of age consent to their enrolment in the PSHCP and to the use and disclosure of their personal information for the above purposes.
4. I agree to the use and disclosure of personal information about my dependants under 18 years of age to enrol them in the PSHCP and for the above purposes.
5. I confirm all dependants I have identified meet the PSHCP eligibility requirements and the information I have provided is complete and accurate.
6. I agree to review and keep up-to-date all my and my dependant's information.
7. I agree to validate and/or update my personal information and, where applicable, the information of my dependants through the completion of the biennial confirmation process. My failure to complete the biennial confirmation process may result in my dependant's claims being suspended until it has been completed.
8. I confirm all goods and services for which reimbursement is claimed by me or my dependant(s) will have been received by me or my dependant(s). In the case of overpayments and/or erroneous payments which I have not reimbursed to Canada Life, I agree that Canada Life may disclose this personal information to the Plan Sponsor, specifically the Treasury Board of Canada Secretariat. The Plan Sponsor/ Treasury Board of Canada Secretariat may disclose this personal information to government institutions so that the overpayments and/or erroneous payments and associated interest (if applicable) can be deducted or set-off from any money due or payable to me by His Majesty.
9. If banking information was provided, I authorize Canada Life to deposit claim payments directly to the account provided.
10. If banking information was provided for Veterans Affairs Canada members for the purpose of contribution collection, I authorize Canada Life to withdraw from the identified bank account.

### Signature

I agree to the submission of the information on this application to Canada Life for enrolling in the PSHCP and I am providing the consent and declarations listed above. A photocopy or electronic version of this signed application is as valid as the original.

Signature X \_\_\_\_\_ Date (mmm-dd-yyyy): \_\_\_\_\_

First and last name:  Plan number(s):   
 VAC Certificate number:

**Account Information**

Name and address of financial institution:   
  
 Transit number:  Financial institution code:  Account number:

**Important Note:** Please provide this PAD agreement, an unsigned blank cheque marked "VOID" or a printout of banking information from your Financial Institution to Canada Life's Benefits Administration Solutions. They must be received by Benefits Administration Solutions at least 14 days prior to the first withdrawal day.

**Terms and conditions of this Personal PAD Agreement**

<p>• <b>Authorization</b></p>	<p><b>Note:</b> References in this form to "this PAD agreement" include later amendments to it.                  I, the account holder, authorize The Canada Life Assurance Company (Canada Life) and my financial institution named above to withdraw monthly, on the 3rd day of each month or the next business day, from my account any payments that I have agreed to make under the Public Service Health Care Plan (PSHCP), and/or as otherwise specified to be made in this PAD agreement as though I had personally signed a cheque. I understand that changes to the Plan(s), including as applicable, to amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the monthly amount withdrawn or to be withdrawn from my account. <b>Accordingly, I authorize such increases or decreases, waiving any pre-notification requirement with respect to them.</b>                  I consent to Canada Life's collection, use, retention and exchange of personal information concerning me, in my capacity as account holder and only as required for purposes relating to this PAD agreement. I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.</p>
<p>• <b>Signatures</b></p>	<p>I certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.</p>
<p>• <b>Account changes</b></p>	<p>I will notify Canada Life if my financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the next withdrawal date. Canada Life may, but is not obligated to, rely on verbal instructions from me to amend this authorization.</p>
<p>• <b>Confirming withdrawals</b></p>	<p>I agree to regularly review my account information and if I question or disagree with the amount withdrawn or any account changes, I will notify Canada Life in writing within 90 days of the withdrawal or account changes; otherwise, I agree that the withdrawal or account changes will be considered to have been properly made.                   Canada Life's contact information for questions related to these withdrawals is: The Canada Life Assurance Company, Benefits Administration Solutions-D227 PO Box 6000 Station Main Winnipeg MB R3C 3A5, telephone 1-855-415-4414.</p>
<p>• <b>Non-sufficient funds (NSF) information</b></p>	<p>If there is not enough money in my account to cover the total amount due ("amount due" meaning the amounts owing related to my coverage under PSHCP), I authorize Canada Life to make subsequent attempts to withdraw the amount due (which include prior months' payments that were uncollected). If subsequent attempt(s) are also returned NSF, I understand that this PAD agreement may be suspended or cancelled, and coverage under PSHCP may be suspended or terminated by Canada Life. I understand that I am responsible for any NSF charge(s).</p>
<p>• <b>Cancellation</b></p>	<p>This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by me to Canada Life or by Canada Life to me.                   To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit <a href="http://payments.ca">payments.ca</a>. To obtain more information on your PAD agreement, contact Canada Life at Benefits Administration Solutions, telephone 1-855-415-4414.                   I agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Canada Life, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Canada Life, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.</p>
<p>• <b>Recourse</b></p>	<p>You have certain recourse rights if any debit does not comply with this PAD 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 information on your recourse rights, contact your financial institution or visit <a href="http://payments.ca">payments.ca</a>.</p>

Signed at: \_\_\_\_\_ on \_\_\_\_\_  
 City Province Month Day Year

Name of account holder \_\_\_\_\_ Name of other joint account holder(s) \_\_\_\_\_  
 X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of account holder \_\_\_\_\_ Signature of other joint account holder(s), if required for account \_\_\_\_\_  
 X \_\_\_\_\_ X \_\_\_\_\_

**Plan Member's Copy**  
**Please keep a copy of this page for your records.**

**Public Service Health Care Plan for Veterans Affairs Canada**  
**Personal Pre-Authorized Debit ("PAD") Agreement**

**Terms and conditions of this Personal PAD Agreement**

<b>• Authorization</b>	<p><b>Note:</b> References in this form to "this PAD agreement" include later amendments to it.</p> <p>I, the account holder, authorize The Canada Life Assurance Company and my financial institution named above to withdraw monthly, on the 3rd day of each month or the next business day, from my account any payments that I have agreed to make under the Public Service Health Care Plan (PSHCP), and/or as otherwise specified to be made in this PAD agreement as though I had personally signed a cheque. I understand that changes to the Plan(s), including as applicable, to amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the monthly amount withdrawn or to be withdrawn from my account. I agree that Canada Life will provide me with at least 10 days advance notice of the amount of the first payment to be withdrawn from my account and I agree to waive any notification of subsequent payments however, Canada Life shall provide me with at least 10 days advance notice of any increases or decreases to such payments</p> <p>I consent to Canada Life's collection, use, retention and exchange of personal information concerning me, in my capacity as account holder and only as required for purposes relating to this PAD agreement. I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.</p>
<b>• Signatures</b>	I certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
<b>• Account changes</b>	I will notify Canada Life if my financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the next withdrawal date. Canada Life may, but is not obligated to, rely on verbal instructions from me to amend this authorization.
<b>• Confirming withdrawals</b>	<p>I agree to regularly review my account information and if I question or disagree with the amount withdrawn or any account changes, I will notify Canada Life in writing within 90 days of the withdrawal or account changes; otherwise, I agree that the withdrawal or account changes will be considered to have been properly made.</p> <p>Canada Life's contact information for questions related to these withdrawals is: The Canada Life Assurance Company, Benefits Administration Solutions-D227 PO Box 6000 Station Main Winnipeg MB R3C 3A5, telephone 1-855-415-4414.</p>
<b>• Non-sufficient funds (NSF) information</b>	If there is not enough money in my account to cover the total amount due ("amount due" meaning the amounts owing related to my coverage under PSHCP), I authorize Canada Life to make subsequent attempts to withdraw the amount due (which include prior months' payments that were uncollected). If subsequent attempt(s) are also returned NSF, I understand that this PAD agreement may be suspended or cancelled, and coverage under PSHCP may be suspended or terminated by Canada Life. I understand that I am responsible for any NSF charge(s).
<b>• Cancellation</b>	<p>This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by me to Canada Life or by Canada Life to me.</p> <p>To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit <a href="http://payments.ca">payments.ca</a>. To obtain more information on your PAD agreement, contact Canada Life at Benefits Administration Solutions, telephone 1-855-415-4414.</p> <p>I agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Canada Life, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Canada Life, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.</p>
<b>• Recourse</b>	You have certain recourse rights if any debit does not comply with this PAD 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 information on your recourse rights, contact your financial institution or visit <a href="http://payments.ca">payments.ca</a> .