Blue Cross Health™

PART I – BASIC INFORMATION

Please print in ink or type information.

APPLICANT'S PERSONAL INFORMATION

Applicant's Last Name (Applicant must be age 16 or older): _____ First Name: _____

Language Preference: ◯ English ◯ French Occupation: _____

Email address*: _____

Address (Street & No.): _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone No.: ___-___-____ HOME ___-___-____ WORK ___-___-____ MOBILE

*Your policy will be issued by email.

COVERAGE

One of the following coverages must be chosen:

◯ **Entry health benefits 60%**
- Health practitioners $250/yr
- Vision Care $100/2 yrs

OR

◯ **Essential health benefits 70%**
- Health practitioners $400/yr
- Vision Care $150/2 yrs
- Includes more benefits and higher maximums

OR

◯ **Enhanced health benefits 80%**
- Health practitioners $500/yr
- Vision Care $300/2 yrs
- Higher maximums, and adds:
  - Semi-Private Hospital and Travel - 30 days (Travel is optional at age 65)

If 65: ◯ Travel ◯ No Travel

You may add any additional benefits to the coverage

◯ **Essential drug benefits 70%**
- 100% coverage after $4,500 (No overall maximum)

OR

◯ **Enhanced drug benefits 80%**
- 100% coverage after $4,500 (No overall maximum)
- Fertility drugs $1,500/yr up to $3,000 per lifetime
- Additional drug coverage

◯ **Entry dental benefits 60%**
- Check up, cleaning and fillings, $500 max/year

OR

◯ **Essential dental benefits 70%**
- Check up, cleaning and fillings
- Extractions and Root Canals no overall maximum

OR

◯ **Enhanced dental benefits 80%**
- Check up, cleaning and fillings, no overall maximum
- Extractions and Root Canals
- Periodontal, Major and Orthodontics. 60% Coverage (Maximums apply)

◯ **Critical Illness**
- Pays cash for unexpected illness (16 Conditions)
- $25,000 member and spouse
- $10,000 Dependents

◯ **Hospital Cash**
- $100 per day hospitalized

◯ **Assured Access**
- Assured Access allows you to put your coverage on hold should you acquire group health benefits.

◯ **Pre-Approved Term Life**
- Automatically approved if 45 and under and qualify medically

Exclusions, waiting periods and other restrictions may apply.

Requested Effective Date of Policy: Please begin my coverage on the 1st day of (month/year): _____

Have you had, or do you now have, Medavie Blue Cross coverage? ◯ Yes ◯ No **If yes, please indicate**

ID Number: _____ Policy Number: _____

Is this application intended to replace your current Medavie Blue Cross policy? ◯ Yes ◯ No

First Name	Last Name	Sex*** M/F/I/U	Date of Birth DD MM YY	Please (✓) if you or your dependents **DO NOT** wish the following coverages: Drug	Dental	Full-Time Student?	Height cm/inches	Weight lbs/kg	Smoker?	Pregnant?
Applicant	00				N/A				Yes/No	Yes/No
Spouse**	01				N/A				Yes/No	Yes/No
Child	02									
Child	03									
Child	04									
Child	05									

If you have checked Yes to the pregnancy question, please supply due date(s): _____

It is necessary to provide the name of each applicant's physician and contact information.

Physician's Name: _____ Telephone Number: _____

Physician's Name: _____ Telephone Number: _____

** Spouse shall mean an individual who is married to the applicant, or in a conjugal relationship for at least one year or resides at the same address as the applicant.

*** Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

PART II — MEDICAL INFORMATION - Please take the time to read carefully and answer the following questions. Should our post-audit process determine that the responses to these questions did not represent complete and full disclosure, this policy could be cancelled without advance notification.

1. Are you and all listed dependents currently covered by a Provincial Health Plan in Atlantic Canada (Medicare in New Brunswick, Medical Services Insurance (MSI) in Nova Scotia, Hospital and Medical Services Ins. in Prince Edward Island or Medical Care Plan (MCP) in Newfoundland)? ○ Yes ○ No

   If no, please explain: _____

2. Has any individual to be covered ever consulted a physician, been treated for or had any indication of:

   A. High blood pressure, stroke, heart attack, heart disease, chest pain or angina? ○ Yes ○ No
   B. Asthma, allergies or other breathing problems? ○ Yes ○ No
   C. Back, neck or knee pain, muscle or joint pain, arthritis or injury? ○ Yes ○ No
   D. Stomach, intestinal, liver or kidney disorder? ○ Yes ○ No
   E. Alcohol or drug dependency? ○ Yes ○ No
   F. AIDS or HIV infection? ○ Yes ○ No
   G. Recurrent infections or elevated cholesterol? ○ Yes ○ No
   H. Diabetes, colitis, Crohn's, acne/rosacea/cold sores or skin disease/disorder or osteoporosis? ○ Yes ○ No
   I. Depression, anxiety or other mental illness, insomnia or other sleep disorder? ○ Yes ○ No
   J. Disease or disorder of the reproductive system or infertility or hormone/menopausal symptoms? ○ Yes ○ No
   K. Cancer or leukemia? ○ Yes ○ No
   L. Chronic headaches, epilepsy or multiple sclerosis? ○ Yes ○ No
   M. Within the last two years, has any individual to be covered been hospitalized? ○ Yes ○ No

3. Within the last two years, has any individual to be covered required:

   A. The services of a chiropractor, physiotherapist, psychologist or podiatrist, naturopath, acupuncturist, massage therapist, athletic therapy or social worker? ○ Yes ○ No
   B. Ostomy supplies, diabetic supplies, maximist, CPAP or TENS machine? ○ Yes ○ No
   C. Orthopedic shoes, orthopedic supplies or arch supports? ○ Yes ○ No
   D. Ambulance services or nursing care? ○ Yes ○ No
   E. Artificial limbs/prosthesis, braces, walker, wheelchair or oxygen? ○ Yes ○ No

Please provide details to "Yes" answers to Question #2 and Question #3

Individual's Name	Condition	Type and Number of Treatments	Date First Treated	Date Last Treated	Results of Treatment/ Extent of Recovery

4. Does any individual to be covered take prescription medication or have a prescription for which refills are currently authorized? (Include all forms of medication - pills, patches, injections, drops, creams and suppositories.) ○ Yes ○ No If you answered "yes", please provide details.

Individual's Name	Prescription Name	Reason for Medication	Strength of Medication	Quantity Taken

5. Does any individual to be covered currently have a referral, testing, treatment, investigation, surgery or appointment contemplated or completed but for which the results have not yet been received? ○ Yes ○ No If you answered "yes", please provide Individual's Name, Condition, Date of Appointments and other pertinent information.

_____

_____

6. Does any individual to be covered have a physical or mental impairment, disease or disorder not stated in the preceding? ○ Yes ○ No
   If you answered "yes", please provide Individual's Name, Condition, Type of Treatment and other pertinent information.

_____

_____

7. During the past three years, have you or any listed dependent had your driver's licence suspended or revoked or been convicted of:
   a) more than three driving violations? b) refusing to take a breathalyzer? or c) driving while impaired? ○ Yes ○ No If "yes", please give details:

_____

_____

PART II — MEDICAL INFORMATION (cont.) - Please take the time to read carefully and answer the following questions. Should our post-audit process determine that the responses to these questions did not represent complete and full disclosure, this policy could be cancelled without advance notification.

8. In the past five years, have you or any listed dependent ever used narcotics (e.g. morphine, heroin), controlled substances (e.g. diazepam, lorazepam), hallucinogens (e.g. LSD, marijuana) or stimulants (e.g. amphetamines, cocaine), except as prescribed by a physician? ◯ Yes ◯ No
If "yes", please give details:

Individual's Name	Type	Usual Quantity	Frequency of Use	Date of Last Usage

AGREEMENT AND CONSENT

I/We, the undersigned, understand and agree that any pre-existing condition/injury or the signs of which that appeared or occurred on or before the date of this application are not covered by this policy. The discovery of facts known by my/our eligible dependents or me/us but not stated on this application could result in the denial of a claim and the cancellation or modification of this policy. I/We further acknowledge that it is my/our responsibility to notify Medavie Blue Cross of any changes in my/our health status or the health of my/our dependents from the date of application until a policy is issued or the effective date, **whichever is later**. Medavie Blue Cross reserves the right to recover any monies paid on my/our behalf or on the behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this application form. I/We agree to repay to Medavie Blue Cross any and all monies paid as a result of the discovery of facts not fully disclosed on this application.

I/We, the undersigned, declare the answers to the above questions are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my/our policy, to recommend suitable products and services to me/us and to manage the Company's business. I/We authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, organization, institute or person, that has any records or knowledge of me/us or my/our health, to give Blue Cross Life, Medavie Blue Cross or their reinsurer any such information. I/We further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/our personal physician or other medical practitioner. This consent is valid for as long as the contract is in force, unless I/we revoke it **in writing**. I/we understand I/we may revoke my/our consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I/We understand why my/our personal information is needed and am/are aware of the risks and benefits of consenting or refusing to consent. I/we can contact Medavie Blue Cross at 1-800-667-4511 should I/we have questions as to the collection, use or disclosure of my/our personal information.

Your personal information will be securely stored using information systems owned or managed by Medavie Blue Cross, its agents and/or its service providers, both inside and outside of Canada. All service providers and agents are contractually bound to protect the confidentiality of all personal information.

I/We acknowledge and agree that there is no coverage and that Medavie Blue Cross is not at risk unless a contract comes into effect as a result of this application.

If I/we do not qualify for an Complete Health personal health plan due to my/our health, I/we consent to allow Medavie Blue Cross to offer a different personal health plan that I/we are qualified for.

This consent complies with federal and provincial privacy laws. (A photographic copy of this authorization shall be as valid as the original.)

Dated on this _____ day of _____ year _____.

_____ SIGNATURE OF APPLICANT

_____ SIGNATURE OF SPOUSE (as defined in policy)

BILLING - PRE-AUTHORIZE DEBIT (PAD)

Name of Payor: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

BANK ACCOUNT INFORMATION - PLEASE PRINT Please attach a void cheque.

Financial Institution: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: ☐☐☐☐☐ ☐☐☐ FI Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐
(branch - 5 digits; FI - 3 digits)

Type of Service: ◯ Personal ◯ Business

I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide monthly pre-notification but will provide 30 days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross.

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 www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Date: _____

Signature(s) of Bank Account Holder(s): _____

PREMIUM RECEIPT

Please detach and give to applicant

Medavie Blue Cross acknowledges receipt of $ _____ paid in connection with the application for Personal Health Coverage. This receipt acknowledges that the sum referred to above has been received on behalf of Blue Cross and NO COVERAGE EITHER EXPRESSED OR IMPLIED is conveyed by the acceptance of such sum. The applicant hereby acknowledges and agrees that THERE IS NO HEALTH COVERAGE resulting from the acceptance of the money and that Blue Cross is not at risk unless a contract comes into effect as a result of this application.

DIRECT DEPOSIT

Eligible Benefits will be reimbursed through electronic funds transfer (direct deposit). I choose to use the same banking information as:
❍ Billing ❍ Use the banking information below. I may cancel this authorization at any time by giving written notice to Blue Cross.

BANK ACCOUNT INFORMATION - PLEASE PRINT
Please attach a void cheque.

Financial Institution: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: ☐☐☐☐☐ ☐☐☐ FI Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐
(branch - 5 digits; FI - 3 digits)

Date: _____ **Signature(s) of Bank Account Holder(s):** _____

QUOTATION WORK SHEET

	Monthly Rates
MANDATORY	
❍ Entry health benefits 60%	
❍ Essential health benefits 70%	
❍ Enhanced health benefits 80%	
OPTIONAL	
❍ Essential drug benefits 70%	
❍ Enhanced drug benefits 80%	
❍ Entry dental benefits 60%	
❍ Essential dental benefits 70%	
❍ Enhanced dental benefits 80%	
❍ Critical Illness	
❍ Hospital Cash	
❍ Assured Access	
MONTHLY TOTAL	
❍ Pre-approved term life	

NOTES

FOR AGENT USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: _____ Agent's Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: ☐☐☐ ☐☐☐

Telephone Number: ☐☐☐-☐☐☐-☐☐☐☐ Fax Number: ☐☐☐-☐☐☐-☐☐☐☐

Email address: _____

Agent's Signature: _____

Agent Comments: _____

Accidental Death and Dismemberment benefits, Life Benefits and Critical Illness will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of money paid, if you are not entirely satisfied.

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