PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

PERSONAL HEALTH INSURANCE INDIVIDUAL PLAN APPLICATION

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2199 | inhealth@pac.bluecross.ca

- Print in ink or type information.
- Only permanent BC residents are eligible for coverage.
- **ALL APPLICANTS** must complete Parts 1, 2, 5 and 6.
- **PART 3: BENEFICIARY DESIGNATION** is not required for Dental Only plans.
- **PART 4: MEDICAL DECLARATION** must be completed if you are applying for a Blue Choice plan. Application must provide a complete medical history of all eligible family members.

BROKER/OFFICE USE ONLY

Application number	ID number	Broker ID (for Broker/Agent use only)

PART 1 — APPLICANT AND DEPENDENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	First name	Last name	Middle initial

Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F	Care Card number (10 digits)	Height	Weight

Street address	City	Province	Postal code

Daytime phone number (10 digits)	Home phone number (10 digits)	Email address	During regular business hours, how may we contact you? ☐ Daytime ☐ Home ☐ Email

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	CARE CARD NUMBER	HEIGHT	WEIGHT
Spouse			(mm-dd-yyyy)	☐ M ☐ F			
First child			(mm-dd-yyyy)	☐ M ☐ F			
Second child			(mm-dd-yyyy)	☐ M ☐ F			
Third child			(mm-dd-yyyy)	☐ M ☐ F			

Spouse means your legal spouse, or a common-law spouse with whom you have been continuously living for the past 12 months. Child means a single, unemployed person under age 21 (19 years of age for Dental Only plan), who is a natural or adopted child of yours or your spouse, and who is financially dependent on you or your spouse. If your child is physically or mentally disabled before attaining age 21, coverage may continue beyond age 21. If you have more than four dependent children, list them on a separate sheet.

PART 2 — APPLICATION FOR BENEFITS: Choose plan from Sections A to C and Travel Insurance Add-On in Section D if desired

I/we are applying for ☐ Single ☐ Couple ☐ Family | Request coverage to begin on the first day of (mm-dd-yyyy): _____

SECTION A — HEALTH AND DENTAL PLAN ☐ Core Extended Health Care Benefits (required)

OPTIONS ☐ Essential Prescription Drug OR ☐ Enhanced Prescription Drug | ☐ Essential Dental OR ☐ Enhanced Dental

☐ Pay Direct Drug Card — available with Enhanced Prescription Drug option and provided there are no pre-existing conditions (see **PART 4**)

☐ Healthy Blue Living Program — qualified individuals receive a discount on the Extended Health portion of their coverage. The discount will be applied upon completion of the medical questionnaire review.

SECTION B — GROUP CONVERSION PLAN ☐ Core Extended Health Care Benefits (required)

OPTIONS ☐ Enhanced Prescription Drug — includes Pay Direct Drug Card | ☐ Essential Dental OR ☐ Enhanced Dental

Conversion Plan options cannot be changed once they are selected. My group coverage was cancelled and I have been covered under a Canadian group plan for the same benefits (i.e. Extended Health and/or Dental) for at least six continuous months in order to be eligible for a Conversion Individual Plan. I am applying within the 60-day time frame. The following information must be completed:

Name of group insurance company	Employer	Employer contact or Plan Administrator

Employer phone number	Group plan number	Benefit ID number/certificate number	Previous benefit effective date (mm-dd-yyyy)	Previous benefit termination date (mm-dd-yyyy)

Benefits included under my existing or previous plans were ☐ Extended Health ☐ Dental ☐ Prescription Drugs
To be eligible, each person on the Conversion Plan must have been included in the Group Plan. Pacific Blue Cross will call to verify group coverage.

Applicant's full name (please print): _____

SECTION C — DENTAL ONLY PLANS

☐ Stand Alone Dental Only Plan

☐ Group Dental Add-On — I am applying for dental coverage as a supplement to my existing Canadian Blue Cross employer group extended health plan:
☐ Essential Dental OR ☐ Enhanced Dental

Canadian Blue Cross plan	Contract number

SECTION D — TRAVEL INSURANCE ADD-ON

☐ Annual Travel (up to 60 years of age): ☐ 15 days ☐ 30 days ☐ 60 days

If you are 61 and over, you may be eligible for Annual Travel, based on your response to our health questionnaire. Please contact us at 604 419-2200, toll-free at 1 800 873-2583 or visit our website at pac.bluecross.ca.

PART 3 — BENEFICIARY DESIGNATION

You (and your spouse, if applicable) should name at least one beneficiary (and trustee, if a beneficiary is under age 18), otherwise applicable benefits will be paid to your (or your spouse's) estate in the event of death (not required if applying for our Stand Alone Dental Only Plan or Group Dental Add-On).

Applicant's beneficiary's full legal name	%	Relationship	Trustee's full legal name
Applicant's beneficiary's full legal name	%	Relationship	Trustee's full legal name
Spouse's beneficiary's full legal name	%	Relationship	Trustee's full legal name
Spouse's beneficiary's full legal name	%	Relationship	Trustee's full legal name

PART 4 — MEDICAL DECLARATION: Complete questions 1–9

MUST BE COMPLETED IN FULL IF APPLYING FOR THE BLUE CHOICE PLAN. This declaration is not required for the Conversion Plan or Dental Only Plans. Based on your family's medical history, coverage may be declined or modified to exclude certain conditions or may be given a higher premium. Expenses incurred as a result of current or past conditions may not be covered unless specified in the agreement letter. Additional information may be requested to underwrite your application.

1. Have you or any listed dependent been diagnosed with, treated, prescribed medication, or had any known indication of any condition during the past 12 months?

☐ Yes ☐ No AIDS, ARC (AIDS related Complex), positive HIV test or any other immunological disorder

☐ Yes ☐ No Hepatitis B, C or B carrier state

☐ Yes ☐ No Stomach, intestinal, liver, kidney or bladder disorder (including ulcers)

☐ Yes ☐ No Mental, nervous or emotional disorder (including depression or anxiety)

☐ Yes ☐ No Bone or joint disorder (including arthritis or rheumatism)

☐ Yes ☐ No Reproductive system disease or disorder or infertility

☐ Yes ☐ No Skin disease or disorder (including acne)

☐ Yes ☐ No Alcohol or drug dependency

☐ Yes ☐ No Diabetes, IDDM/NIDDM

☐ Yes ☐ No Colitis, or Crohn's, IBS or any other bowel disorder

☐ Yes ☐ No Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)

☐ Yes ☐ No Chronic headaches or migraine headaches

☐ Yes ☐ No Neurological disorder, seizures, multiple sclerosis or paralysis

☐ Yes ☐ No Cancer, tumour or leukemia

☐ Yes ☐ No Chest and heart conditions

☐ Yes ☐ No High blood pressure, stroke, blood disorder or elevated cholesterol

☐ Yes ☐ No Hernia

☐ Yes ☐ No Attention deficit hyperactive disorder

☐ Yes ☐ No Chronic fatigue or Fibromyalgia

☐ Yes ☐ No Back, limb or neck strain/pain

☐ Yes ☐ No Any physical impairments, deformities or illnesses not covered above

2. Have you or any listed dependent required or used medical equipment in the past 12 months or in the foreseeable future need medical equipment?

☐ Yes ☐ No Artificial limbs, braces, walker or cane

☐ Yes ☐ No Hearing aid

☐ Yes ☐ No Wheelchair

☐ Yes ☐ No Oxygen

☐ Yes ☐ No Diabetic supplies or equipment

☐ Yes ☐ No Ostomy supplies

☐ Yes ☐ No Nebulizer

☐ Yes ☐ No Orthopedic shoes, orthopedic supplies or arch supports

☐ Yes ☐ No Ambulance services or nursing care

☐ Yes ☐ No Non-traditional medicinal therapy (Naturopathic or Homeopathic)

Applicant's full name (please print): _____

3. Have you or any listed dependent consulted or received treatment from a medical professional in the past two years?

☐ Yes ☐ No Physician (other than a general check-up)
☐ Yes ☐ No Chiropractor
☐ Yes ☐ No Physiotherapist
☐ Yes ☐ No Acupuncturist
☐ Yes ☐ No Massage Therapist
☐ Yes ☐ No Chiropodist/Podiatrist
☐ Yes ☐ No Psychologist

4. Provide details for each **YES** answer given in **QUESTIONS 1–3** as well as details on any additional physical impairments, disease or disorders that you or your dependents have that are not listed.

PERSON'S NAME	ILLNESS/ CONDITION OR EQUIPMENT SPECIALIST	FIRST TREATMENT DATE	TREATMENT DURATION	TREATMENT TYPE	TREATMENT RESULTS/EXTENT OF RECOVERY	TREATMENT PROVIDER (NAME/ADDRESS/ PHONE)
		(mm-dd-yyyy)				
		(mm-dd-yyyy)				
		(mm-dd-yyyy)				
		(mm-dd-yyyy)				

5. Have you or any listed dependent taken any prescription medication for any reason in the last six months or have a prescription for which refills are currently authorized (including oral medication, serum, injection, drops, creams and suppositories)? ☐ Yes ☐ No
If **YES**, provide details below:

PERSON'S NAME	PRESCRIPTION NAME	STRENGTH	QUANTITY TAKEN	COST PER MONTH	NUMBER OF REFILLS PER YEAR	REASON

6. Are you or any listed dependent pregnant? ☐ Yes ☐ No
If **YES**, what is the person's name: _____ and due date (mm-dd-yyyy): _____

7. Have you or any listed dependent smoked or used tobacco and/or cannabis in the last 12 months? ☐ Yes ☐ No — If **YES**, please provide details below:

PERSON'S NAME	TYPE OF TOBACCO/CANNABIS USE	HOW OFTEN (E.G. NUMBER PER DAY)

8. During the past five years, have you or any listed dependent used cocaine, hallucinogenic or narcotics (e.g. morphine or heroin), sedatives or tranquilizers, except as prescribed by a physician? ☐ Yes ☐ No
If **YES**, indicate person's name(s), type and how often per day: _____

9. **APPLICANT DECLARATION (Complete only if NO medical conditions)**
If in the foregoing **QUESTIONS 1–8** you answered **NO** throughout and you and your dependents have no physical impairments, disease or disorders, please confirm by initialing in the box to the right.

Applicant's initials

Applicant's full name (please print): _____

PART 5 — PAYMENT METHOD (Choose one method below)

POLICY SPONSOR INFORMATION Bank account/credit card holder, only if different from the Applicant

First name	Last name	Daytime phone number (10 digits)	
Street address	City	Province	Postal code

PAYMENT FREQUENCY ☐ Monthly ☐ Annually — in the amount of: $ _____

☐ **Pre-authorized debit (PAD)** — Attach a cheque marked VOID or a pre-authorized payment form provided by your bank that identifies your branch and account information. This will only apply to the payment being withdrawn from your banking account (PAD). If you wish to change your banking information to receive claims payments in that same account, please contact us. The only frequency available for PAD is monthly. Pre-authorized payment account type: ☐ Business ☐ Personal.

☐ **Annual cheque** — Attach a cheque for one full year's premium payable to Pacific Blue Cross.

In accordance with Payments Canada safety and privacy regulations, we will call you to obtain your credit card information. **DO NOT** write your full credit card number on this application form.

Credit card ☐ Visa ☐ Mastercard ☐ American Express Name on card _____ Expiry date | 2 digits | 4 digits

PART 6 — AUTHORIZATION

I (We) authorize PBC to make deductions, from the credit card or bank account indicated, either through monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under the Member's policy. Each debit will occur on or about the first business day of the month, beginning on the effective date of coverage.

I (We) agree to waive the requirement for PBC to notify me (us) of this authorization before the first payment is processed and any subsequent monthly regular payment.

The withdrawal amount is considered variable under the Payments Canada rules. PBC will provide me (us) at least three (3) business days written notice should there be a change in either the amount of the monthly regular payment or premium due date. Any notices, to be sent under this agreement, will be sent to the Member's most recent address that PBC has on record at the time a notice is sent. All persons, whose signatures are required to sign on this account, have signed this authorization.

Pacific Blue Cross may terminate coverage, or change the method of payment with written approval of the Policy Sponsor to another qualifying method, should a withdrawal be refused for any reason. Pacific Blue Cross will charge a fee for any withdrawal that is not honoured.

I (We) will notify PBC in writing of any changes in the account information or termination of this authorization within ten (10) business days prior to the next debit. I/We have certain rights if any debit does not comply with this agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit payments.ca.

Account/card holder's signature	Second account/card holder's signature (if required)	Date (mm-dd-yyyy)
X	X	

PART 7 — APPLICANT SIGNATURE

I confirm that the information I have provided is true and complete. I understand that I and my dependents (if applicable) must be continuously enrolled under all applicable provincial health plans in order to participate in this contract.

If I should receive a settlement against a liable third party for benefits covered under this contract, I agree to, and authorize the third party to, reimburse Pacific Blue Cross up to the amount advanced to me pending such settlement or judgement.

I understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which appeared on or before the date of this application, may not be covered. I understand that not accurately and fully disclosing all information requested on this application, could result in a denial of claims and a cancellation, or modification of the contract.

I understand and consent that some of the personal information provided by me and my dependents (if applicable) may be disclosed to agents and representatives of Pacific Blue Cross and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent to the retention, use and disclosure of this personal information in accordance with Pacific Blue Cross' privacy policy. I authorize any medical practitioner, hospital, clinic, pharmacy and any British Columbia government health agency (including PharmaCare) or other medically related facility that has my health information to transfer the information to Pacific Blue Cross. This includes my health records and the health records of my covered dependents (if applicable), and details of coverage eligibility. A copy of our privacy policy is available by contacting Pacific Blue Cross. It is also available on our website at pac.bluecross.ca.

Applicant's signature	Applicant's full name (print)	Date (mm-dd-yyyy)
X	X	