PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

PERSONAL HEALTH INSURANCE GUARANTEED ACCEPTANCE 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 parts must be completed.

OFFICE USE ONLY

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

PART 1 — APPLICANT INFORMATION

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

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

Street address	City	Province	Postal code

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

PART 2 — DEPENDENT INFORMATION

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	CARE CARD NUMBER
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, 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 four or more dependent children, list them on a separate sheet.

PART 3 — BENEFIT SELECTION

I/we are applying for ☐ Single ☐ Couple ☐ Family

Effective date — First of the month following acceptance of your application

EXTENDED HEALTH (Required) ☐ Essential ☐ Bronze ☐ Silver ☐ Gold

DENTAL (Optional for Essential and Bronze Health, mandatory for Silver and Gold Health)

☐ Bronze Dental (Available with Essential, Bronze or Silver Health)
☐ Silver Dental (Available only with the selection of Silver or Gold Health)
☐ Gold Dental (Available only with the selection of Gold Health)

PART 4 — 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.

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

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 Canadian Payments Association 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 cdnpay.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	