MEDAVIE BLUE CROSS™

Options®

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6
FOR ALL INQUIRIES: **1-800-667-4511**

APPLICATION FOR PERSONAL HEALTH PLAN

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):* _____

Language Preference: ☐ English ☐ French Occupation: _____

Address (Street & No.): _____

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

Telephone No.: ☐☐☐-☐☐☐-☐☐☐☐ HOME ☐☐☐-☐☐☐-☐☐☐☐ WORK ☐☐☐-☐☐☐-☐☐☐☐ CELLULAR/PAGER

E-mail address: _____

COVERAGE

OPTIONS PLUS

- ☐ Principal Benefits *(Mandatory)*
  If 65+: ☐ Travel ☐ No Travel
- ☐ Drugs *(Optional)*
- ☐ Dental *(Optional)*
- ☐ Critical Care *(Optional)*
- ☐ *Assured Access* Module *(Optional at time of purchase only)*
- ☐ Pre-approved Term Life*

OPTIONS®

- ☐ Principal Benefits *(Mandatory)*
- ☐ Drugs *(Optional)* ☐ No Deductible ☐ Deductible
- ☐ Dental *(Optional)*
- ☐ Critical Care *(Optional)*
- ☐ Hospital Cash *(Optional)*
- ☐ *Assured Access* Module *(Optional at time of purchase only)*
- ☐ Pre-approved Term Life*

**Automatically approved if under age 40 and qualify medically.*

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 NO. _____ POLICY NO.

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

FIRST NAME INITIAL SURNAME		SEX M/F	DATE OF BIRTH DD	MM	YYYY	STATUS† E or S	HEIGHT	WEIGHT	SMOKER Y/N	PREGNANT‡ Y/N	NAME OF PHYSICIAN
Applicant	00										
Spouse/Cohabitant *(as defined in policy)*	01										
Children	02										
	03										
	04										
	05										

† Over-age dependent status: E = attending college or university S = physically or mentally disabled

‡ Please note that coverage for maternity benefits or conditions arising out of pregnancy are available only after eight (8) months of continuous coverage.

FOR MEDAVIE BLUE CROSS USE ONLY

I.D. No.: _____ CASH OFFICE: Amount Received: _____ ☐ Agent ☐ Branch ☐ Client

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. Have you or any listed dependent **ever** consulted a physician, been treated for or had any indication of:

A.	Chest pain, heart or circulatory trouble or irregular heart rate (fast or slow)	☐ Yes	☐ No
B.	High blood pressure, stroke, blood disorder or elevated cholesterol	☐ Yes	☐ No
C.	Cancer, tumour (benign/malignant) or leukemia	☐ Yes	☐ No
D.	Diabetes/elevated sugar levels, colitis or Crohn's disease	☐ Yes	☐ No
E.	AIDS, ARC (Aids Related Complex) or other immunological disorder	☐ Yes	☐ No
F.	Alcohol or drug dependency	☐ Yes	☐ No
G.	Stomach, intestinal, liver, kidney or bladder disorder	☐ Yes	☐ No
H.	Bone, muscle or joint disorder/arthritis/osteoporosis	☐ Yes	☐ No
I.	Depression or anxiety disorder, nervous breakdown, mental illness, insomnia or other sleep disorder (i.e. sleep apnea)	☐ Yes	☐ No
J.	Respiratory disorder, asthma or allergies	☐ Yes	☐ No
K.	Disease or disorder of the reproductive system or infertility or hormone/menopausal symptoms	☐ Yes	☐ No
L.	Chronic headaches/migraines or recurrent infection	☐ Yes	☐ No
M.	Acne/rosacea/cold sores or skin disease/disorder	☐ Yes	☐ No
N.	Brain or neurological disorder, epilepsy, convulsion, loss of consciousness or multiple sclerosis	☐ Yes	☐ No

If you answered "yes" to any of the above questions, please give details below:

Person's Name	Condition	Date First Treated	Duration of Treatment	Type of Treatment	Results of Treatment/ Extent of Recovery

3. Do you or any listed dependent currently take any prescription medication or have a prescription for which refills are currently authorized? (Please consider all forms of medication, i.e., oral, serums, injections, drops, creams and suppositories.) ☐ Yes ☐ No If you answered "yes", please give details:

Person's Name	Prescription Name	Strength	Quantity Taken	Reason

4. Within the past two years, have you or any listed dependent received, used or required:

a)	treatment from a chiropractor, podiatrist, physiotherapist, psychologist, naturopath, acupuncturist or massage therapist?	☐ 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

If you answered "yes" to any of the above questions, please give details below:

Person's Name	Type & Number of Treatments	Date First Treated	Date Last Treated	Reason for Treatment	Results of Treatment/ Extent of Recovery

5. Do you, or any listed dependent, 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 give details:

   _____

6. Within the last three years have you or any listed dependent been hospitalized? ☐ Yes ☐ No If you answered "yes", please give details:

Person's Name	Date	Duration	Reason	Name of Physician	Result

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.

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:

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:

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

9. Do you or any listed dependent have a physical impairment, disease or disorder not stated above? ☐ Yes ☐ No If "yes", please give details:

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.

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.

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/COHABITANT *(as defined in policy)*

PLEASE COMPLETE THE PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT BELOW.

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 from 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 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: _____ Authorized Signature(s): _____

Type of Service: ○ Personal ○ Business

Please attach a void cheque or complete the form below. (Credit card payments are not accepted.)

PLEASE PRINT

Financial Institution (FI): _____

Address: _____

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

FI Transit Number: ☐☐☐☐☐ ☐☐☐ FI Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐

(branch - 5 digits; FI - 3 digits)

If someone other than the policy owner will be paying the premiums, please have them sign, date and complete their financial information above and complete their personal information below:

Name of Payer: _____ Address: _____

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

Telephone Number: (Business) _____ - _____ - _____ (Residence) _____ - _____ - _____

Refunds for any overpayment are to be made payable to the applicant.

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 Medavie 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 Medavie Blue Cross is not at risk unless a contract comes into effect as a result of this application.

QUOTATION WORK SHEET

Options Plus

	Monthly Rate
MANDATORY	
Principal Benefits Module	
OPTIONAL	
Drug Module	
Dental Module	
Critical Care Module	
Assured Access Module	
MONTHLY TOTAL	

Options

	Monthly Rate
MANDATORY	
Principal Benefits Module	
OPTIONAL	
Drug Module— No Deductible	
Deductible	
Dental Module	
Critical Care Module	
Hospital Cash Plan Module	
Assured Access Module	
MONTHLY TOTAL	

The Drug Module with a deductible is only available with the Options® *plan. These rates are subject to approval based on satisfactory evidence of health. Rates are subject to change between the date of application and the policy effective date.*

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: Go Benefits Agent's Number: 9611

Address: 100 Park Street

City/Town: Moncton Province: NB Postal Code: E1C 2B3

Telephone Number: 506-384-7687 Fax Number: 506-388-9486

E-mail address:

Agent's Signature:

Agent Comments:

Accidental Death and Dismemberment benefits, Life Benefits and Critical Care 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.

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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