Application

BLUE CROSS®

HELPFUL TIPS FOR COMPLETING YOUR BLUE CROSS APPLICATION

The following helpful tips will assist you in completing your application

TIP #1 – CHECKLIST

When completing the application use the checklist located on pages IV and V. This way you will be sure to have completed all the necessary information and ensure the quickest possible processing of your client's application.

TIP #2 – SIGNATURES

Missing signatures are one of the main reasons applications are returned. The enclosed checklist indicates the pages that will require a signature indicated by a  .

Be sure to double check that you have all of the signatures.

TIP #3 – PHONE INTERVIEW

There are many benefits to a phone interview, such as the elimination of unnecessary correspondence due to missing information (for example: special questionnaires and attending physician statements).

Experts will contact your client and will collect information from your client in a professional manner.

By checking section 8, we will be solely responsible for requesting all relevant medical and non-medical information from your client for the purpose of the underwriting analysis.

TIP #4 – SPECIAL QUESTIONNAIRES

(applicable only if the phone interview services are not used)

Certain questions on the Health statement indicate **"If yes, questionnaire to be completed"**. By being pro-active and submitting one in advance along with the application you could reduce the underwriting significantly and save yourself a second trip back to your client to have one completed. Special questionnaires are provided in your broker kit.

TIP #5 – ONTARIO AND QUEBEC SYMBOLS

Sections marked with  apply to Ontario applicants only and sections marked with  apply to Quebec applicants only.

TIP #6 – TANGIBLE LONG-TERM CARE AND CRITICAL ILLNESS ELIGIBILITY

Please refer to sections 7.1 and 7.2 prior to completing the application to ensure you are eligible to apply for these benefits.

APPLICATION NUMBER

Checklist (Sections to be Completed)

BLUE VISION / BLUE FLEX PRODUCT (EXPRESS PLAN AND GLOBAL PLAN)

	SECTIONS	PAGES	✓
Personal information	1A	1	
If the person to be insured has chosen benefits that include family, couple or single-parent coverage	1C	2	
Policyholder information (If different from Primary Insured)	2	2	
Beneficiary or beneficiaries	3A	3	
Occupation information	4	4	
Effective insurance	5	5	
Method of payment	6.1	5	
Pre-authorized debit (PAD) agreement (To be completed if the person to be insured has chosen the monthly direct debit method of payment)	6.2	6	
Phone interview	8	9	
Declaration	9	11 and/or 12	
To be given to the person to be insured if required: Temporary insurance coverage	10	13	
Authorizations (for the Primary Insured and the spouse if required)	Detachable section	17	
To be given to the person to be insured: Receipt, Notice regarding personal information and Notice regarding the Medical Information Bureau and exchange of information	To be given	19	
For representatives use only	12	21	

TANGIBLE PRODUCT

	SECTIONS	PAGES	✓
Personal information	1A	1	
Policyholder information (If different from Primary Insured)	2	2	
Beneficiary or beneficiaries	3B	3	
Occupation information	4	4	
Effective insurance	5	5	
Method of payment	6.1	5	
Pre-authorized debit (PAD) agreement (To be completed if the person to be insured has chosen the monthly direct debit method of payment)	6.2	6	
Preliminary questionnaire for Critical illness benefits	7.1	7	
Preliminary questionnaire for Long-term care and Hybrid coverage benefits	7.2	7	
Phone interview	8	9	
Declaration	9D	12	
To be given to the person to be insured if required: Temporary insurance coverage–Tangible	11	15	
Authorizations	Detachable section	17	
To be given to the person to be insured: Receipt, Notice regarding personal information and Notice regarding the Medical Information Bureau and exchange of information	To be given	19	
For representatives use only	12	21	

MORTGAGE PLAN PRODUCT

	SECTIONS	PAGES	✓
Personal information	1A and 1B	1 and 2	
Policyholder information (If different from Borrower)	2	2	
Beneficiary in case of death	3C	3	
Effective insurance	5	5	
Method of payment	6.1	5	
Pre-authorized debit (PAD) agreement (To be completed if the person to be insured has chosen the monthly direct debit method of payment)	6.2	6	
Phone interview	8	9	
Declaration	9D	12	
Authorizations (for the Borrower and the Co-borrower if required)	Detachable section	17	
To be given to the Borrower: Receipt, Notice regarding personal information and Notice regarding the Medical Information Bureau and exchange of information	To be given	19	
For representatives use only	12	21	

Contract no. _____ Spouse application no. _____ APPLICATION NUMBER

Application

TYPE OF APPLICATION

IMPORTANT NOTE
You must be a beneficiary as defined by the health and hospital insurance legislation in your province of residence.

☐ Blue Vision (Ontario)
- ☐ Express Plan
- ☐ Global Plan

☐ Blue Flex (Quebec)
- ☐ Express Plan
- ☐ Plan Flex

☐ Tangible
- ☐ Mortgage Plan

☐ New enrolment
☐ Change
☐ Reinstatement (lapsed policy for more than 90 days)

CURRENT POLICY NUMBER

REPRESENTATIVE INFORMATION

Name of firm

Representative (administrator)
NAME % REPRESENTATIVE CODE

Other representative (if applicable)
NAME % REPRESENTATIVE CODE

1. PERSONAL INFORMATION

NOTE **The fields for Last name, First name, Date of birth and Age must be completed prior to printing the application.**

A) PRIMARY INSURED/ BORROWER

LANGUAGE CHOICE
☐ French
☐ English

May we include your name on a Blue Cross solicitation list?
☐ Yes ☐ No

Last name _____ First name _____

Date of birth
DAY MONTH YEAR AGE

Place of birth*
COUNTRY, PROVINCE

Sex ☐ M ☐ F

☐ Non-smoker ☐ Smoker

Civil status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Common-law marriage

* If you are not a Canadian citizen, please indicate if you are:
☐ Permanent resident (landed immigrant)
☐ Other (please specify): _____

TELEPHONE E-MAIL

Address
NO. STREET APT. CITY PROVINCE POSTAL CODE

Principal occupation

OCCUPATION DATE OF HIRING % OF TIME

NAME OF EMPLOYER/BUSINESS EMPLOYER/BUSINES TELEPHONE

NATURE OF BUSINESS EMPLOYER/BUSINESS E-MAIL

Address
NO. STREET SUITE EMPLOYEE TELEPHONE AT WORK

CITY PROVINCE POSTAL CODE EMPLOYEE E-MAIL AT WORK

Other occupation

OCCUPATION DATE OF HIRING % OF TIME

Annual salary or net annual earnings:

(AFTER EXPENSES AND BEFORE TAXES)

B) CO-BORROWER
(To be completed for Mortgage Plan)

Last name _____ First name _____

Sex ☐ M ☐ F Date of birth _____ (DAY) _____ (MONTH) _____ (YEAR) Age _____

TELEPHONE [HOME] | TELEPHONE [WORK] | E-MAIL

NAME OF EMPLOYER | EMPLOYER TELEPHONE | EMPLOYER/BUSINESS E-MAIL

OCCUPATION | DATE OF HIRING | Number of hours worked _____ HRS / WEEK

C) FAMILY, COUPLE OR SINGLE-PARENT COVERAGE

If you have chosen a benefit that includes family, couple or single-parent coverage, please complete this section:

SPOUSE LAST NAME	FIRST NAME	SEX	DATE OF BIRTH DAY	MONTH	YEAR	AGE
		☐ M ☐ F				

DEPENDENT CHILD LAST NAME	FIRST NAME	RELATIONSHIP	SEX	DATE OF BIRTH DAY	MONTH	YEAR	AGE
			☐ M ☐ F				
			☐ M ☐ F				
			☐ M ☐ F				
			☐ M ☐ F				

2. POLICYHOLDER INFORMATION (IF DIFFERENT FROM PRIMARY INSURED OR BORROWER)

LANGUAGE CHOICE
☐ French
☐ English

Last name _____ First name _____

If the policyholder is a company _____
NAME OF THE COMPANY

Sex ☐ M ☐ F Date of birth _____ (DAY) _____ (MONTH) _____ (YEAR) Age _____

TELEPHONE [HOME] | TELEPHONE [WORK] | E-MAIL

Address

NO. | STREET | APT. | CITY | PROVINCE | POSTAL CODE

3. BENEFICIARY OR BENEFICIARIES

A) BLUE VISION / BLUE FLEX

NOTE FOR QUEBEC RESIDENTS ONLY

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

B) TANGIBLE

Benefit(s) payable in case of death of the primary insured

Subject to the provisions of this benefit, the Insurer undertakes to pay the benefit(s) to the beneficiary or beneficiaries designated below in case of death of the Primary Insured.

☐ Life – Hybrid coverage ☐ Critical illness ☐ Premium refund upon death ☐ Loss of autonomy – Hybrid coverage

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

☐ Life – Hybrid coverage ☐ Critical illness ☐ Premium refund upon death ☐ Loss of autonomy – Hybrid coverage

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

Benefit(s) payable during the lifetime of the primary insured

Subject to the provisions of this benefit, the Insurer undertakes to pay the benefit(s) to the Primary Insured unless otherwise specified below.

☐ Critical illness ☐ Premium refund (20) – Critical illness ☐ Premium refund (65) – Critical illness

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

☐ Critical illness ☐ Premium refund (20) – Critical illness ☐ Premium refund (65) – Critical illness

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

C) MORTGAGE PLAN (MORTGAGE LIFE ONLY)

BENEFICIARY IN CASE OF DISABILITY

Benefits payable for and on behalf of the totally disabled insured are paid directly to the creditor who must use them to reduce the outstanding balance of the disabled insured's mortgage loan.

Borrower

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

Co-borrower

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

4. OCCUPATION INFORMATION

To be completed only if you wish to apply for disability insurance, monthly indemnity or overhead expenses (Global Plan (Ontario) / Flex Plan (Quebec) or Tangible).

A) EMPLOYEES, COMPANY OWNERS AND SELF-EMPLOYED

a) Do you want to provide proof of income: ☐ with your application ☐ when you make a claim
If the amount of insurance you are applying for is $3 500 or more **OR** you elect to submit proof of income with your application no matter what amount of insurance you are applying for, please provide complete financial evidence for the last **two** years.

b) Are you: ☐ an employee ☐ a company owner ☐ self-employed

c) Do you contribute to: Employment Insurance? ☐ Yes ☐ No

The WSIB (Ontario) / The CSST (Quebec)? ☐ Yes ☐ No

d) Professional titles or diploma: _____

e) If you have been employed for less than 1 year, please indicate previous employment: _____

f) Do you work at least 20 hours a week? ☐ Yes ☐ No

g) Do you work at least 8 months a year? ☐ Yes ☐ No

B) COMPANY OWNERS AND SELF-EMPLOYED ONLY

a) Number of associates/shareholders: _____ % of shares: _____

b) Do you have firm contracts for the next 12 months? ☐ Yes ☐ No

If yes, specify: _____

c) Do you work from home? ☐ Yes ☐ No If yes, is your office accessible to the public? ☐ Yes ☐ No

Percentage (%) of time working outside home: _____

d) Job duties – Please indicate the job functions and the percentage of time dedicated to carrying out each one of them:

DUTIES	PERCENTAGE OF TIME	DESCRIPTION OF FUNCTION
a) Manual labour	%	
b) Management/office	%	
c) Sales	%	
d) Supervision	%	
e) Location: office	%	
workshop/plant	%	
on site	%	

5. EFFECTIVE INSURANCE

☐ I do not have any effective insurance.
☐ I already have a Blue Cross policy. Please indicate the contract number: _____

Do you have any other life, disability, critical illness, long-term care or mortgage disability/life policy, including through your employer?
☐ Yes ☐ No If yes, please complete the following information:

NAME OF PRIMARY INSURED / BORROWER OR CO-BORROWER	COMPANY	TYPE OF CONTRACT (Life, disability, critical illness, long-term care or mortgage disability and life)	INDIVIDUAL	GROUP	EFFECTIVE DATE	AMOUNT
			☐	☐		
			☐	☐		
			☐	☐		
			☐	☐		
			☐	☐		
			☐	☐		

If this application is to replace an existing policy or policies, please list the policy or policies below:

NAME OF THE COMPANY _____ COVERAGE _____ TERMINATION DATE [DD / MM / YYYY] _____

NAME OF THE COMPANY _____ COVERAGE _____ TERMINATION DATE [DD / MM / YYYY] _____

6.1 METHOD OF PAYMENT

☐ **CREDIT CARD PAYMENT**

PAYMENT TYPE
☐ Monthly
☐ Annual

☐ Amex
☐ MasterCard
☐ VISA

Card no. ____ ____ ____ ____

Expiration date ____ (MONTH) ____ (YEAR)

SIGNATURE OF CARDHOLDER _____

NAME (PLEASE PRINT) _____

☐ **MONTHLY PRE-AUTHORIZED DEBIT**

Please sign the pre-authorized debit (PAD) agreement on page 6 and attach a void cheque.
Would you like your first premium to be debited directly from your account? ☐ Yes ☐ No
If no, please attach a cheque for the first premium amount.

☐ **ANNUAL CHEQUE**

Please attach a cheque payable to BLUE CROSS CANASSURANCE.

☐ Payment received
A cheque in the amount of $_____ representing the first premium payment is attached herewith.
Would you like a receipt for income tax purposes? ☐ Yes ☐ No

6.2 PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

A) PAYOR INFORMATION

Last and first names of account holders (please print)

Account holder

LAST NAME

FIRST NAME

Joint account holder

LAST NAME

FIRST NAME

FOR ADMINISTRATION ONLY

Contract no.

Insured's name

Address

NO. STREET APT. CITY PROVINCE POSTAL CODE

TELEPHONE MOBILE E-MAIL

B) BANK ACCOUNT INFORMATION

NOTE

Type of service: personal

Financial institution

NAME INSTITUTION NO. BRANCH TRANSIT NO. ACCOUNT NO.

Address

NO. STREET SUITE CITY PROVINCE POSTAL CODE

C) AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1. I, the undersigned, hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $_____, for payment of my insurance contract. If no date is entered, I understand that the date may be determined by the Insurer without giving me prior notice.

   Desired withdrawal date: _____ (excluding the 29th, 30th and 31st). I have attached a void cheque ☐

   I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing for my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all pre-authorized debits (PAD) withdrawn from my account are fixed or variable-amount personal PADs.
2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to send me prior notice of thirty (30) days only for the renewal of my policy.
3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution. I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.
4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten (10) business days prior to a PAD.
5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service department at **1 866 722-3444 in Ontario** or at **1 800 363-3958 in Quebec**. **I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD**.
6. I understand that I may revoke this authorization at any time subject to providing ten (10) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit **www.cdnpay.ca**.
7. I understand that the Insurer may cancel this Agreement upon thirty (30) days written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.
8. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

D) SIGNATURE

SIGNATURE OF THE ACCOUNT HOLDER

FIRST AND LAST NAME (PLEASE PRINT)

DATE [DD/MM/YYYY]

SIGNATURE OF JOINT ACCOUNT HOLDER (IF APPLICABLE)

FIRST AND LAST NAME (PLEASE PRINT)

DATE [DD/MM/YYYY]

APPLICATION NUMBER

Tangible

7.1 PRELIMINARY QUESTIONNAIRE FOR CRITICAL ILLNESS BENEFITS

To be eligible for the Critical illness, Critical illness – Hybrid coverage or Critical illness Multi-protection benefit, you must answer **No** to all of the questions in this section

Do you have or have you ever had any of the following conditions or symptoms?	YES	NO
Heart attack, angina, coronary artery bypass surgery, percutaneous coronary intervention (angioplasty or other method of occlusion removal) or stroke?	☐	☐
Cancer? (some exceptions may apply; consult the underwriting department)	☐	☐
Insulin-dependent diabetes?	☐	☐
Kidney failure, polycystic kidney disease?	☐	☐
Alzheimer's disease, Parkinson's disease, Huntington's disease, muscular dystrophy or multiple sclerosis?	☐	☐
Cystic fibrosis?	☐	☐
AIDS, HIV positive, AIDS-related complex (ARC) or hepatitis C?	☐	☐
Alcohol or drug abuse during the last 3 years?	☐	☐
Major organ transplant or on a waiting list?	☐	☐

7.2 PRELIMINARY QUESTIONNAIRE FOR LONG-TERM CARE AND HYBRID COVERAGE BENEFITS

To be eligible for the Facility care, Home care, Hospitalization and Loss of autonomy and Hybrid coverage benefits, you must answer **No** to all of the questions in this section

Do you have or have you ever had any of the following conditions or symptoms?	YES	NO
AIDS, HIV positive, AIDS-related complex (ARC)?	☐	☐
Insulin-dependent diabetes?	☐	☐
Alzheimer's disease, Parkinson's disease, Huntington's chorea, memory loss, dementia, senility, cerebral palsy or a brain disease or disorder?	☐	☐
Multiple sclerosis, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease/Charcot's disease), rheumatoid arthritis or muscular dystrophy?	☐	☐
Liver cirrhosis, hepatitis C, active hepatitis B or major organ transplant?	☐	☐
Paralysis, stroke (two episodes or more) or transient ischemic attack (two episodes or more)?	☐	☐
Amputation due to disease?	☐	☐
Bladder or bowel incontinence, long-term disability or disability recognized by the CPP or by provincial authorities?	☐	☐
Osteoporosis with fractures, lupus other than discoid lupus erythematosus?	☐	☐
Cystic fibrosis, pulmonary fibrosis?	☐	☐
Sickle cell anemia, leukemia?	☐	☐
Alcohol or drug abuse during the last 3 years?	☐	☐

At the present time…	YES	NO
Do you use a cane, a walker, a wheelchair or an oxygen device?	☐	☐
Are you waiting for surgery?	☐	☐
Are you undergoing renal dialysis?	☐	☐
Are you suffering from dizziness for which a diagnosis has not been made yet?	☐	☐

During your lifetime…	YES	NO
Have you ever attempted to commit suicide?	☐	☐

8. PHONE INTERVIEW

1ST STEP

NOTE

As you have requested a phone interview, a health statement is not required.

To optimize the interview process, please indicate in the chart below the best time for a specialist to call you for information about your health and lifestyle. Information obtained during the phone interview is considered confidential information.

Please indicate the phone number you would prefer to be contacted: _____

TELEPHONE

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2
9 AM–12 PM												
12 PM – 2 PM												
2 PM – 4 PM												
4 PM – 6 PM												
6 PM – 9 PM												

Insured 1: Primary Insured/Borrower Insured 2: Spouse/Co-borrower

If the client does not speak English or French, the phone interview is mandatory. Please complete the section above.

2ND STEP

If you have completed the above section, Blue Cross will be responsible for the phone interview process directly with your client and **will be accountable for obtaining all medical requirements stated in section 12B on page 21**.

Do you have a preference among our authorized paramedical companies? ☐ Yes ☐ No

_____

PREFERED PARAMEDICAL COMPANY

If no choice has been specified, Blue Cross will designate a paramedical company, who will complete any additional tests (blood profile, urine, etc.)

APPLICATION NUMBER

9. DECLARATION

A) DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT (EXPRESS PLAN)

1. The person to be insured hereby declares that he/she has not had a Critical illness insurance application or reinstatement of insurance declined, postponed or accepted with special conditions during the past two (2) years.

2. The person to be insured hereby declares that he/she has never consulted a doctor, been hospitalized, demonstrated symptoms of or presented health problems, taken drugs or received a treatment for any of the following conditions:

   a) Cardiovascular disorders: heart attack, angina, arrhythmia, pacemaker, defibrillator, high blood pressure, heart failure, bypass, angioplasty, valvulopathy or valve replacement, aortic aneurysm, heart transplant, peripheral vascular disease or any other heart surgery

   b) Chronic obstructive pulmonary disorders: asthma, emphysema, chronic bronchitis, lung transplant

   c) Neurological disorders: stroke, transient cerebral ischemia (TCI)

   d) Insulin-dependent diabetes: diabetes treated with insulin

   e) Kidney failure, kidney transplant

   f) Gastrointestinal disorders: cirrhosis, hepatitis, ulcer, internal bleeding, liver transplant, surgery for bowel obstruction

   g) Cancer or malignant tumour

3. The person to be insured declares that he/she have not undergone in the last five (5) years a course of treatment for detoxification (closed or open treatment) following alcohol or drug consumption, and has not had hard drug usage in the last five (5) years such as: opium, heroine, morphine, codeine, demerol, barbiturates, amphetamines, cocaine, hallucinogens or anabolic steroids, or methadone, prescribed or not by a doctor.

4. The person to be insured hereby declares that he/she is not awaiting any medical test results and he/she is not under medical investigation.

Signed in _____ this _____ day of _____

CITY | DAY | MONTH, YEAR

_____ _____

SIGNATURE OF THE PERSON TO BE INSURED | SIGNATURE OF REPRESENTATIVE

9. DECLARATION (CONTINUED)

B) DECLARATION FOR MONTHLY INDEMNITY DUE TO ILLNESS EXPRESS (if applicable)

The person to be insured hereby declares that he/she has not, for the last three (3) years:

a) had an insurance application declined, postponed or accepted with special conditions

b) been treated or consulted for use of alcohol or drugs

c) been hospitalized twice or more (except for pregnancy)

d) been treated or taken medication for cancer, tumor, cardiovascular disorders or neurological disorders or psychological disorders, diabetes, kidney failure, high blood pressure superior to 170/100 (maximal indicator exceeds 170 or minimal indicator exceeds 100)

C) DECLARATION FOR ALL EXPRESS PLAN BENEFITS (if applicable)

NOTE

The Express Plan benefits shall take effect one minute after midnight on the day following the signing of the application, provided that the first premium is paid in full.

On the date of signing this application, each person to be insured declares the following:

a) He/she is not disabled

b) He/she is not hospitalized or waiting to be hospitalized

c) He/she does not have or has never been diagnosed with breast cancer

d) He/she did not have or has never been diagnosed or been treated for any other type of cancer in the past five (5) years

e) He/she did not have or has never been diagnosed with AIDS or any form of pre-AIDS

D) DECLARATION FOR ALL BENEFITS FROM EVERY PRODUCT

NOTE

No representative is authorized to establish or modify the Insurer's contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of the Insurer.

1. Each person to be insured, hereby declares that he/she holds a valid health card from their provincial health plan as defined by the health and hospital insurance legislation in his/her province of residence.
2. Each person to be insured, hereby declares that all answers given in this application and in any other document which, by agreement forms a part thereof are true and complete. We, the persons to be insured, understand that any omission or misrepresentation statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.
3. Each person to be insured, hereby confirms that he/she has been informed of all statements recorded in this application.
4. The Primary Insured asks that Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insured, issue a contract as specified herein.
5. This declaration offers no guarantee of insurance.
6. The Primary Insured acknowledges receipt of the "Notice regarding personal information" and "Notice regarding the Medical Information Bureau and exchange of information".

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age) (Primary Insured or Borrower)	SIGNATURE OF SPOUSE OR CO-BORROWER	SIGNATURE OF REPRESENTATIVE

APPLICATION NUMBER

Temporary Insurance Coverage

TO BE GIVEN TO THE PERSON TO BE INSURED

10. BLUE VISION – GLOBAL PLAN (ONTARIO) / BLUE FLEX – FLEX PLAN (QUEBEC)

EFFECTIVE DATE OF THE TEMPORARY INSURANCE COVERAGE

1. This temporary insurance coverage comes into effect if the following conditions are met:
   a) The initial premium is paid in full when the insurance is purchased.
   b) Based on the application, the person to be insured is an insurable risk at the regular rate according to Blue Cross standards.
2. This temporary insurance coverage is effective as of the latest of the following dates:
   a) The date the duly completed application is signed.
   b) The date on which all underwriting requirements are completed.
   c) The date on the cheque issued to pay the first premium.
3. In case of misstatement or omission that could affect risk assessment before the contract comes into effect, no temporary insurance coverage is provided.

This temporary coverage ends after ninety (90) days or on the day the contract takes effect if within less than ninety (90) days.

Blue Cross reserves the right to terminate this temporary insurance coverage at any time.

Only the following benefits are included in this temporary coverage: Monthly indemnity due to accident, Disability due to accident and Term life 65.

Under this temporary insurance coverage, the Monthly indemnity due to accident benefit is limited to $500/month for a maximum of three months, the Disability due to accident benefit is limited to $1 000/month for a maximum of three months and the Term life 65 benefit is limited to $50 000.

REPRESENTATIVE'S SIGNATURE

DATE [DD/MM/YYYY]

APPLICATION NUMBER

Temporary Insurance Coverage

TO BE GIVEN TO THE PERSON TO BE INSURED

11. TANGIBLE

A) EFFECTIVE DATE OF THE TEMPORARY INSURANCE COVERAGE

1. This temporary insurance coverage comes into effect if the following conditions are met:
   a) The initial premium is paid in full when the insurance is purchased or if the initial premium has been paid in full by pre-authorized debit.
   b) Based on the application, the person to be insured is an insurable risk at the regular rate according to Blue Cross standards.
2. This temporary insurance coverage is effective as of the latest of the following dates:
   a) The date the duly completed application is signed.
   b) The date on which all underwriting requirements are completed.
   c) The date on the cheque issued to pay the first premium.
3. In case of misstatement or omission that could affect risk assessment before the contract comes into effect, no temporary insurance coverage is provided.

B) CONDITIONS

Long-term care

Maximum monthly indemnity is as follows, depending on the monthly indemnity selected in the insurance application:

FACILITY CARE HOME CARE	$1 500 per month but not exceeding the selected amount insured and subject to a maximum of six months (for these benefits combined)

Life – Hybrid coverage

Maximum amount insured is as follows, depending on the amount insured selected in the insurance application:

LIFE [HYBRID COVERAGE]	$300 000 but not exceeding the selected amount of insurance (for all life insurance contracts held with the insurer)

Critical illness

Maximum amount insured is as follows, depending on the amount insured selected in the insurance application:

CRITICAL ILLNESS CRITICAL ILLNESS [MULTI-PROTECTION] CRITICAL ILLNESS [HYBRID COVERAGE] LOSS OF AUTONOMY [HYBRID COVERAGE]	$100 000 but not exceeding the selected amount insured (for these benefits combined)

Disability – Hybrid coverage

The maximum monthly indemnity is as follows, depending on the monthly indemnity selected in the insurance application:

DISABILITY [HYBRID COVERAGE]	$1 000 per month but not exceeding the selected amount insured and subject to a maximum of three (3) months. In addition, this temporary insurance applies only for disability due to accident or injury.

C) END OF THE TEMPORARY INSURANCE COVERAGE

1. This temporary insurance coverage ends on the earliest of the following dates:
   a) The date on which the person to be insured cancels the insurance application before the contract comes into effect.
   b) The date on which Blue Cross declines the insurance application.
   c) Three months after the date the application is signed by the person to be insured if the contract is still not in effect on this date.
   d) The date on which the Primary Insured is approved by Blue Cross.
2. Blue Cross reserves the right to terminate this temporary insurance coverage at any time.

D) EXCLUSIONS

No benefits are payable under this temporary insurance coverage if the claim is caused directly or indirectly by any of the following:

a) Abuse of alcohol or drugs, or use of illegal drugs.

b) Cancer diagnosed before or after this temporary insurance coverage comes into effect.

c) Critical illness diagnosed before this temporary insurance coverage comes into effect.

d) Suicide, attempted suicide or intentional self-injury regardless of the state of mind of the person to be insured.

REPRESENTATIVE'S SIGNATURE

DATE [DD/MM/YYYY]

APPLICATION NUMBER

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
(NOT APPLICABLE TO THE EXPRESS PLAN BENEFITS)

For purposes of evaluating and determining my eligibility and the eligibility of my dependent children for insurance products and benefits, I authorize any licensed physician, health professional, hospital, medical facility, insurance company, reinsurance company, the Medical Information Bureau (MIB), the Régie de l'assurance maladie du Québec or any other organization, agency, institution, broker, agent, employer, representative or person holding records or knowledge on myself or on my dependent children, including medical history, to give any such information to Canassurance Hospital Service Association and/or Canassurance Insurance Company (hereafter the Insurer), its reinsurer, its auditors and to any organization or professional appointed by the Insurer in the processing of my request.

I hereby authorize the Insurer, or its reinsurers, to make a brief report of my personal health information to MIB to exchange information held by the Insurer with the abovementioned persons and organizations.

This authorization shall be valid throughout the duration of the contract.

A photocopy of this authorization is as valid as the original.

SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age in Ontario and 14 years of age in Quebec)	**NAME (PLEASE PRINT)**	**DATE [DD/MM/YYYY]**

APPLICATION NUMBER

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
(NOT APPLICABLE TO THE EXPRESS PLAN BENEFITS)

For purposes of evaluating and determining my eligibility and the eligibility of my dependent children for insurance products and benefits, I authorize any licensed physician, health professional, hospital, medical facility, insurance company, reinsurance company, the Medical Information Bureau (MIB), the Régie de l'assurance maladie du Québec or any other organization, agency, institution, broker, agent, employer, representative or person holding records or knowledge on myself or on my dependent children, including medical history, to give any such information to Canassurance Hospital Service Association and/or Canassurance Insurance Company (hereafter the Insurer), its reinsurer, its auditors and to any organization or professional appointed by the Insurer in the processing of my request.

I hereby authorize the Insurer, or its reinsurers, to make a brief report of my personal health information to MIB to exchange information held by the Insurer with the abovementioned persons and organizations.

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SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age in Ontario and 14 years of age in Quebec)	**NAME (PLEASE PRINT)**	**DATE [DD/MM/YYYY]**

APPLICATION NUMBER

TO BE GIVEN TO THE PERSON TO BE INSURED (PRIMARY INSURED OR BORROWER)

RECEIPT

Received for _____ , the person to be insured, the amount of $ _____ for this insurance application submitted to Blue Cross. This amount corresponds to the first premium.

_____ _____

REPRESENTATIVE'S SIGNATURE DATE [DD/MM/YYYY]

NOTICE REGARDING PERSONAL INFORMATION

By applying for our insurance product(s), you are consenting to our collecting, using and disclosing your personal information for the purpose of appraising your insurance application, confirming your coverage and/or benefits, and processing or paying your claims.

The personal information contained in this document will be kept on a confidential basis, in your Canassurance Hospital Service Association and/or Canassurance Insurance Company Insurance file.

Your personal information will only be accessible by our employees and authorized representatives who require access to your file for the purposes set out above.

On written request, you may review the personal information in this file and require that your file be updated or corrected.

For additional information regarding the manner in which we collect, use, disclose and otherwise manage your personal information, please visit our website or write to us:

IN ONTARIO

www.useblue.com

CHIEF PRIVACY OFFICER
CANASSURANCE HOSPITAL SERVICE ASSOCIATION AND/OR
CANASSURANCE INSURANCE COMPANY
185 The West Mall, Suite 610
Etobicoke Ontario M9C 5P1
privacyofficer@ont.bluecross.ca

IN QUEBEC

www.qc.bluecross.ca

MANAGER, ACCESS TO INFORMATION
QUÉBEC BLUE CROSS
1981, McGill College Avenue, Suite 105
Montreal Quebec H3A 0H6

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU AND EXCHANGE OF INFORMATION

Information regarding your insurability will be treated as confidential. The Insurer or the Insurer's reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members, if you apply to another Bureau member company for life or health coverage, the Bureau, on request, will supply such company with the information about you in its files.

All insurers including Canassurance Hospital Service Association and/or Canassurance Insurance Company sometimes write investigative consumer reports in applying standards on processing of applications. The report generally includes information on those to be insured and their life style.

Upon request from you, the Medical Information Bureau will arrange to disclose to you the information in your file, except for medical information, which will be given only to your doctor. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and ask to have it corrected.
The address of the Bureau's Information Office is as follows:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7

Telephone: 416 597-0590
Fax: 416 597-1193

"MIB receives personal information and the collection, use and disclosure of such information is governed by the *Personal Information Protection and Electronic Documents Act (PIPEDA)* in Ontario and by the *Act respecting the Protection of Personal Information in the Private Sector* in Quebec and all similar provincial or federal laws."

Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the Company's privacy and security practices, and in accordance with applicable Ontario or Quebec and Canadian laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at privacy@mib.com

APPLICATION NUMBER

12. FOR REPRESENTATIVES USE ONLY

A) GENERAL INFORMATION

Important

a) Should the Express Plan benefits be issued on the same date as the Global Plan/Flex Plan benefits?

☐ Yes ☐ No

b) I personally met with the client (applicable only for life insurance). ☐ Yes ☐ No

If the answer is No, please explain why:

c) I provided the Temporary insurance coverage certificate to the client. ☐ Yes ☐ No

d) In order to allows us to do a complete evaluation, please provide any additional information that you think may assist in the evaluation. If necessary, please provide details or directives for the completion of the application.

B) MEDICAL REQUIREMENTS

*** For Global Plan/Flex Plan and Mortgage Plan only:** When one of these examinations is ordered, the insurance representative is not required to complete the Health statement or the phone interview section on page 9.

Did you select the phone interview to replace the health statement? ☐ Yes ☐ No

If you answered No, please arrange to have your client complete all medical requirements:

- ☐ Paramedical examination *
- ☐ Medical examination *
- ☐ Chest X-ray
- ☐ Financial questionnaire
- ☐ H.I.V. urine
- ☐ Blood profile
- ☐ Blood profile (with PSA for men)
- ☐ ECG at rest
- ☐ Exercise ECG
- ☐ Vital signs
- ☐ Regular investigation
- ☐ Amplified investigation

Requested on:

DATE [DD/MM/YYYY] | FIRM | REFERENCE NO.

If the client does not speak English or French, the phone interview is mandatory.