Contract no.

Spouse application no.

APPLICATION NUMBER

Application

TYPE OF APPLICATION

☐ Express Plan ☐ SME Plan ☐ Association

NAME OF SME OR ASSOCIATION

IMPORTANT NOTE

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

☐ 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

A) PRIMARY INSURED

Last name | First name

LANGUAGE CHOICE

☐ French

☐ English

May we include your name on a Blue Cross solicitation list?

☐ Yes ☐ No

Date of birth

DAY | MONTH | YEAR | AGE

Place of birth*

COUNTRY, PROVINCE

Sex ☐ M ☐ F

☐ Non-smoker ☐ Smoker

* If you are not a Canadian citizen, please indicate if you are:

☐ Permanent resident (landed immigrant)

☐ Other (please specify):

Civil status

☐ Single

☐ Married

☐ Divorced

☐ Common-law marriage

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)

APPLICATION NUMBER

B) 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)

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

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

4. OCCUPATION INFORMATION
(FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE SME PLAN OR ASSOCIATION PLAN ONLY)

To be completed only if you wish to apply for disability insurance, monthly indemnity or overhead expenses.

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 (FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE SME PLAN OR ASSOCIATION PLAN ONLY)

☐ 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	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]

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 5 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]

7. DECLARATION – EXPRESS PLAN

A) DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT

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

   *If the person to be insured reports having high blood pressure that is well controlled according to the attending physician, with medical monitoring and a blood pressure reading of less than 170/100, the person to be insured may sign the Declaration for Critical Illness Assistance Benefit.

   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

7. DECLARATION – EXPRESS PLAN (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

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.

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. 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
2. 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.
3. 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.
4. Each person to be insured, hereby confirms that he/she has been informed of all statements recorded in this application.
5. The Primary Insured asks that Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insured, issue a contract as specified herein.
6. This declaration offers no guarantee of insurance.
7. The Primary Insured acknowledges receipt of the "Notice regarding personal information" and "Notice regarding the Medical Information Bureau and exchange of information".

Signed in ______________ this ______________ day of ______________
CITY DAY MONTH, YEAR

SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age)	SIGNATURE OF SPOUSE	SIGNATURE OF REPRESENTATIVE

8. SME FORM (ONTARIO)

A) SHORTENED DECLARATION

NOTE

If the persons to be insured have completed a health statement and have been accepted by the Insurer, the Insurer agrees not to apply the limitation of the pre-existing conditions.

1. Each person to be insured hereby declares that he/she has never had an insurance application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions (**clause applicable only for SME employees without disability insurance in force**).

2. Each person to be insured acknowledges the following:

   Exclusion for pre-existing conditions (applicable for the Term life 65, Monthly indemnity due to accident and illness, Disability due to accident and illness and the Overhead expenses benefits).

   With regard to any amount granted with the SME form declaration, no benefit will be payable for a claim relating to an event occurring within twelve (12) months following the effective date of coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed diagnostic tests in the twelve (12) month period preceding the effective date of coverage.

Signed in ____________ this ________ day of ____________
CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED | SIGNATURE OF SPOUSE | SIGNATURE OF REPRESENTATIVE

Note: No representative is authorized to establish or modify a Canassurance Hospital Service Association and/or Canassurance Insurance Company contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Canassurance Hospital Service Association and/or Canassurance Insurance Company.

B) SHORTENED HEALTH STATEMENT

(to be completed for Drug benefit deluxe coverage)

	PRIMARY INSURED	SPOUSE	CHILDREN
1. Over the last twelve (12) months, have those to be insured taken or currently take any medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have those to be insured ever been informed by a doctor that they are suffering from a chronic disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

QUESTION NO.	PERSON'S FIRST NAME	DETAILS OF DIAGNOSIS, TREATMENT MEDICATION AND PRESENT CONDITION	DATE OF EACH OCCURRENCE	SYMPTOM DURATION	DURATION OF ABSENCE FROM WORK	NAMES AND ADDRESSES OF DOCTORS AND MEDICAL ESTABLISHMENTS

Each person to be insured, hereby declares that all answers and explanations given in this form are true and complete. Each person to be insured, understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

Signed in ____________ this ________ day of ____________
CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED | SIGNATURE OF SPOUSE | SIGNATURE OF REPRESENTATIVE

APPLICATION NUMBER

9. SME FORM (QUEBEC)

A) PERSONAL INFORMATION

Have you been covered by the same insurer for a group insurance policy for the past 2 years? ☐ Yes ☐ No

If yes, with which insurer?

Note: If you answered yes, the exclusion for pre-existing conditions mentioned in the **Declaration (option A)** does not apply.

B) DECLARATION (OPTION A)

NOTE

If the persons to be insured have completed a health statement and have been accepted by the Insurer, the exclusion for pre-existing conditions will not apply to those mentioned in the health statement.

NOTE

No representative is authorized to establish or modify a Canassurance Hospital Service Association and/or Canassurance Insurance Company contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Canassurance Hospital Service Association and/or Canassurance Insurance Company.

1. Each person to be insured, hereby declares that on the date of signature of the present application:
   a) He/she is not disabled, hospitalized or waiting to be hospitalized, does not have or have had cancer, AIDS or any form of pre-AIDS
   b) He/she is presently working
   c) He/she has never had a life, monthly indemnity, disability, overhead expenses insurance application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions **(clause applicable only for SME employees without disability insurance in force)**
   d) Over the past twenty-four (24) months, he/she has not consulted, been followed or treated by a doctor or taken medication for any of the following:
      - Psychological, nervous, mental or emotional disorders (such as depression, stress, anxiety, exhaustion, behavioural disorders, chronic fatigue or chronic pain syndrome or fibromyalgia)
      - Joints disorders (such as arthritis, arthrosis, tendonitis, bursitis)
      - Spinal column disorders (such as hernia, lumbar pain, neck pain)
2. Furthermore, each person to be insured acknowledges the following:

   Exclusion for pre-existing conditions (applicable for the Term life 65, Monthly indemnity due to accident and illness, Disability due to accident and illness and the Overhead expenses benefits).

   With regard to any amount granted with SME's form declaration, no benefit will be payable for a claim relating to an event occurring within twelve (12) months following the effective date of coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed diagnostic tests in the twelve (12) month period preceding the effective date of coverage.
3. Each person to be insured, hereby declares that all answers and explanations given in this form are true and complete.
4. Each person to be insured understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

Signed in ______________ this ______________ day of ______________

CITY | DAY | MONTH, YEAR

SIGNATURE OF PRIMARY INSURED

SIGNATURE OF SPOUSE

SIGNATURE OF REPRESENTATIVE

9. SME FORM (QUEBEC) (CONTINUED)

C) DECLARATION (OPTION B)

NOTE

No representative is authorized to establish or modify a Canassurance Hospital Service Association and/or Canassurance Insurance Company contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Canassurance Hospital Service Association and/ or Canassurance Insurance Company.

1. Each person to be insured, hereby declares that on the date of signature of the present application:
   a) He/she is not hospitalized or waiting to be hospitalized or waiting for surgery, nor be the object of a medical investigation for the purpose of establishing a diagnosis
   b) He/she is presently working
   c) He/she has never had an insurance application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions
   d) Over the past twenty-four (24) months, he/she has not consulted, been followed or treated by a doctor or taken medication for any of the following:
      - Psychological, nervous, mental or emotional disorders (such as depression, stress, anxiety, exhaustion, behaviour disorders, chronic fatigue or chronic pain syndrome or fibromyalgia)
      - Joints disorders (such as arthritis, arthrosis, tendonitis, bursitis)
      - Spinal column disorders (such as hernia, lumbar pain, neck pain)
      - Neurological disorders (such as Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis, epilepsy)
      - Drugs or alcohol dependency
      - Cancer or tumour
      - Heart or vascular disorders including CVA
      - Diabetes
      - Hepatitis B and C
      - Chronic obstructive pulmonary disease
      - Inflammatory or auto-immune disease (such as Crohn's disease, ulcerative colitis, pancreatitis, lupus)
      - Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or any other immune-system disorder
      - Renal failure
2. Each person to be insured, hereby declares that all answers and explanations given in this form are true and complete.
3. Each person to be insured understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

Signed in ____________ this ________ day of ____________
CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED | SIGNATURE OF SPOUSE | SIGNATURE OF REPRESENTATIVE

D) SHORTENED HEALTH STATEMENT

(to be completed for Extended health benefit with drug coverage)

	PRIMARY INSURED	SPOUSE	CHILDREN
1. Over the last twelve (12) months, have those to be insured taken or currently take any medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have those to be insured ever been informed by a doctor that they are suffering from a chronic disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

QUESTION NO.	PERSON'S FIRST NAME	DETAILS OF DIAGNOSIS, TREATMENT MEDICATION AND PRESENT CONDITION	DATE OF EACH OCCURRENCE	SYMPTOM DURATION	DURATION OF ABSENCE FROM WORK	NAMES AND ADDRESSES OF DOCTORS AND MEDICAL ESTABLISHMENTS

Each person to be insured, hereby declares that all answers and explanations given in this form are true and complete. Each person to be insured, understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

Signed in ____________ this ________ day of ____________
CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED | SIGNATURE OF SPOUSE | SIGNATURE OF REPRESENTATIVE

10. ASSOCIATION FORM

A) DECLARATION

NOTE

If the persons to be insured have completed a health statement and have been accepted by the insurer, the exclusion for pre-existing conditions above mentioned will not apply to those mentioned in the health statement.

NOTE

No representative is authorized to establish or modify a Canassurance Hospital Service Association and/or Canassurance Insurance Company contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Canassurance Hospital Service Association and/or Canassurance Insurance Company.

1. Each person to be insured hereby declares the following:

a) That he/she has not been diagnosed or has consulted a health professional for one of the following conditions:

- Musculoskeletal Disorder (that caused the applicant to miss work in the last twelve (12) months)
- Spine Diseases (causing the applicant to miss more than five (5) business days of work in the last twenty-four (24) months)
- Alzheimer's Disease
- Thoracic or Abdominal Aortic Aneurysm
- Rheumatoid Arthritis or Psoriatic Arthritis
- Breast Cancer
- Cancer (diagnosed in the past 5 years, excluding basal cell carcinoma of the skin and cervical cancer in situ)
- Liver Cirrhosis
- Diabetes Mellitus (type 1 or 2)
- Epilepsy (Grand mal, attack within 6 months)
- Chronic Fatigue Syndrome
- Fibromyalgia
- Hepatitis (B or C)
- Chronic Renal Failure
- Transient Ischemic Attack
- Leukemia
- Lymphoma
- Systemic Lupus Erythematosus
- Heart Diseases (Angina Pectoris, Myocardial Infarction, Coronary Artery Bypass, Coronary Artery Angioplasty, Acute Coronary Syndrome) or Valvular Heart Disease (Including all Valvular Heart Disease)
- Inflammatory Intestinal Disease (causing the applicant to miss more than fifteen (15) business days of work in the last twenty-four (24) months)
- Chronic Obstructive Pulmonary Disease
- Peripheral Vascular Disease
- Chronic Pancreatitis
- Parkinson's Disease
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis
- Acquired Immune Deficiency Syndrome (AIDS)
- Myeloproliferative Syndrome
- Organ Transplants
- Psychological or Psychiatric Disorders (currently under treatment or having required one year or more of treatment in the past)
- Drug Dependence
- Alcohol Abuse

b) Not being hospitalized or disabled on the date of the signature of the present application;

c) Never has had an application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions.

2. Each person to be insured acknowledges the following:

Exclusion for pre-existing conditions (applicable for the Term life 65, Life hybrid, Monthly indemnity due to accident and illness, Disability due to accident and illness, Disability hybrid and the Overhead expenses benefits).

With regard to any amount granted with the Association Form declaration, no benefit will be payable for a claim relating to an event occurring within twelve (12) months following the effective date of coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed diagnostic tests in the twelve (12) month period preceding the effective date of coverage.

Signed in ____________ this ________ day of ______________
CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED	SIGNATURE OF SPOUSE	SIGNATURE OF REPRESENTATIVE

10. ASSOCIATION FORM (CONTINUED)

B) SHORTENED HEALTH STATEMENT

ONTARIO APPLICANTS ONLY

To be completed for **Deluxe drug coverage** only.

QUEBEC APPLICANTS ONLY

To be completed for **Extended health benefit with drug coverage**.

	PRIMARY INSURED	SPOUSE	CHILDREN
1. Are the persons to be insured currently taking any medication, or have they taken any medication in the last twelve (12) months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have the persons to be insured ever been informed by a doctor that they are suffering from a chronic disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered “yes” to any of the questions above, please provide details below:

QUESTION NO.	PERSON’S FIRST NAME	DETAILS OF DIAGNOSIS, TREATMENT MEDICATION AND PRESENT CONDITION	DATE OF EACH OCCURRENCE	SYMPTOM DURATION	DURATION OF ABSENCE FROM WORK	NAMES AND ADDRESSES OF DOCTORS AND MEDICAL ESTABLISHMENTS

Each person to be insured hereby declares that all answers and explanations given on this form are true and complete. Each person to be insured understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

Signed in ______________ this ______ day of ______________

CITY DAY MONTH, YEAR

SIGNATURE OF PRIMARY INSURED

SIGNATURE OF SPOUSE

SIGNATURE OF REPRESENTATIVE

APPLICATION NUMBER

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

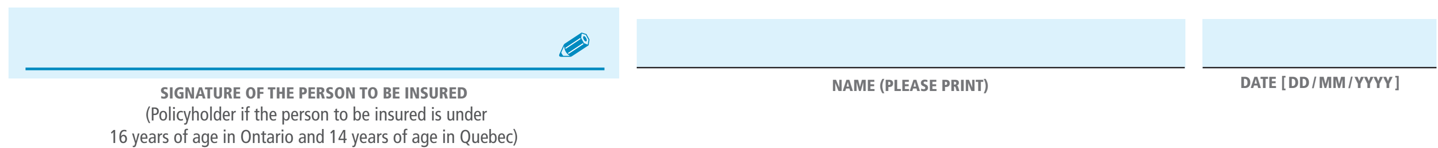
FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH SME PLAN OR ASSOCIATION PLAN ONLY

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]

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

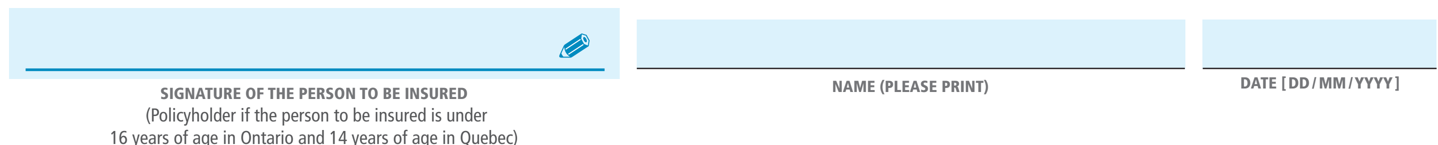
FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH SME PLAN OR ASSOCIATION PLAN ONLY

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]

AUTHORIZATION

AUTHORIZATION

APPLICATION NUMBER

TO BE GIVEN TO THE PERSON TO BE INSURED

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

550 Sherbrooke Street West, Suite B-9
Montreal Quebec H3A 3S3

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU AND EXCHANGE OF INFORMATION

FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH SME PLAN OR ASSOCIATION PLAN ONLY

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

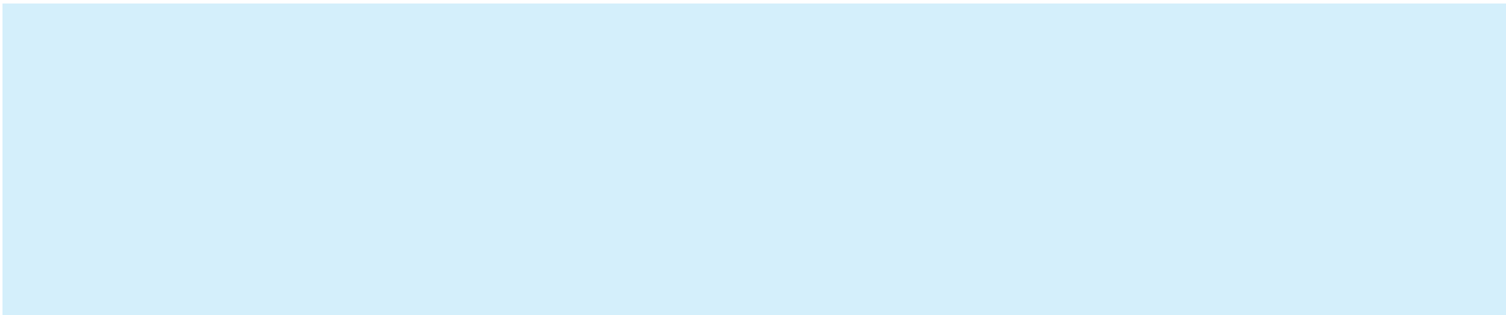
"MIB receives personal information and the collection, use and disclosure of such information is governed by the *Personal Information Protection and Electronic Documents Act (PIPEDA)* in Ontario and by the *Act respecting the Protection of Personal Information in the Private Sector* in Quebec and all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

RECEIPT

NOTICE REGARDING PERSONAL INFORMATION

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU AND EXCHANGE OF INFORMATION



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