PACIFIC BLUE CROSS™ BC Life®

Individual Plan Application

Mailing Address:
PO Box 7000
Vancouver BC V6B 4E1

Street Address:
4250 Canada Way
Burnaby BC

Phone: 604 419-2200
Toll-free: 1 800 USE-BLUE
Fax: 604 419-2199

E-mail: inhealth@pac.bluecross ca
Web site: www.pac bluecross.ca

Broker ID (for Broker/Agent use only)
PBC use only: Issued ID

Part 1 Applicant Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | Last name

First name and initial(s)	Birthdate (mm/dd/yyyy)	Sex ☐ M ☐ F	Care Card number

Address	City	Province	Postal code

Home telephone (ten digits)	Work telephone (ten digits)	Cell phone (ten digits)	E-mail address

If additional information is required during regular business hours, how may we contact you? ☐ Home ☐ Work ☐ E-mail

Part 2 Dependent Information

Last name	First name and initial(s)	Birthdate	Sex	Care Card number
Spouse		mm/dd/yyyy	☐ M ☐ F	
Child		mm/dd/yyyy	☐ M ☐ F	
Child		mm/dd/yyyy	☐ M ☐ F	
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 more than three dependent children, list them on a separate sheet.

Part 3 Application for Benefits

I/We are applying for ☐ Single ☐ Couple ☐ Family coverage Request coverage to begin on the first day of _________________ (mm/yyyy)

A BLUE CHOICE

☐ Core Extended Health Care Benefits (required)

Options:

☐ Essential Prescription Drug **or** ☐ Enhanced Prescription Drug ☐ Essential Dental **or** ☐ Enhanced Dental

☐ Direct Pay Drug Card – available with Enhanced Prescription Drug option and provided there are no pre-existing conditions (see Part 5)

B BLUE CHOICE CONVERSION

☐ Core Extended Health Care Benefits (required)

Options:

☐ Enhanced Prescription Drug – includes Direct Pay Drug Card ☐ Essential Dental **or** ☐ Enhanced Dental

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

Name of group insurance company	Employer	Employer contact or Plan Administrator

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

Benefits included under my existing or previous plan were: ☐ Extended Health ☐ Dental ☐ Prescription Drugs

To be eligible, each person on the conversion plan must have been included in the group plan. Pacific Blue Cross will call to verify group coverage.

C DENTAL ONLY PLANS

☐ Stand Alone Dental Only Plan

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

Policy number	Member ID number

ADD-ONS

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

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

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. (Not required if applying for our Stand Alone Dental Only Plan or Group Dental Add-on.)

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

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Part 5 Pre-existing Medical Conditions Declaration

Have you, or any dependent named on the application, been diagnosed with, treated, prescribed medication, or had any known indication of any condition during the past 12 months? Check (✔) where appropriate and provide details for each condition that you have checked. Expenses incurred as a result of a pre-existing condition(s) are not covered under these plans unless an applicant qualifies for conversion privileges (see Part 3B).

Condition	Yes	No
AIDS, ARC (AIDS related Complex), positive HIV test or any other immunological disorder	☐	☐
Hepatitis B, C or B carrier state	☐	☐
Stomach, intestinal, liver, kidney or bladder disorder (including ulcers)	☐	☐
Mental, nervous or emotional disorder (including depression or anxiety)	☐	☐
Bone or joint disorder (including arthritis or rheumatism)	☐	☐
Reproductive system disease or disorder or infertility	☐	☐
Skin disease or disorder (including acne)	☐	☐
Alcohol or drug dependency	☐	☐
Diabetes, IDDM/NIDDM	☐	☐
Colitis, or Crohn's, IBS or any other bowel disorder	☐	☐
Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)	☐	☐
Chronic headaches or migraine headaches	☐	☐
Neurological disorder, seizures, multiple sclerosis or paralysis	☐	☐
Cancer, tumour or leukemia	☐	☐
Chest and heart conditions	☐	☐
High blood pressure, stroke, blood disorder or elevated cholesterol	☐	☐
Hernia	☐	☐
Attention deficit hyperactive disorder	☐	☐
Chronic fatigue or Fibromyalgia	☐	☐
Back, Limb or neck strain/pain	☐	☐
Any physical impairments, deformities or illnesses not covered above	☐	☐

Provide details of all pre-existing conditions **listed or not listed** below. **OR** We have no pre-existing medical conditions. Initial to confirm. Applicant's initials

Person's name	Illness/condition or equipment specialist	Date of first treatment	Duration of treatment	Type of treatment	Results of treatment/ extent of recovery	Treatment provider (name/address/phone)

Part 6 Payment (Complete steps A–D)

A **Policy Sponsor Information** (Bank Account/Credit Card Holder, if different from the Applicant)

Name (last, first)		Home telephone (ten digits)	
Address	City	Province	Postal code

B Payment Frequency ☐ **Monthly** ☐ **Annually** in the amount of $ ____________

C Payment Method **1** Monthly Pre-Authorized Payment, or **2** Annual Cheque, or **3** Credit Card

1 ☐ **Monthly Pre-Authorized Payment** — Attach a cheque marked VOID or a Pre-Authorized Payment Form provided by your bank that identifies your branch and account information.

Pre-Authorized payment account type ☐ Business ☐ Personal

Authorization *— I/We authorize Pacific Blue Cross to make deductions, from the 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 Applicant'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 Pacific Blue Cross to notify me/us of this authorization before the first payment is processed and any subsequent monthly regular payment. *Pacific Blue Cross 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 Applicant's most recent address that Pacific Blue Cross has on record at the time a notice is sent.*

This authorization shall remain in effect until Pacific Blue Cross has received written notification from me/us of its change or termination. This notification must be received ten (10) business days prior to the next pre-authorized payment date. The Policy Sponsor and /or the Applicant may contact Pacific Blue Cross for more information using the contact information located on page one of this form.

Pacific Blue Cross may terminate coverage, or change the method of payment with approval of the Policy Sponsor to another qualifying method, should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $20.00 NSF fee will be charged by Pacific Blue Cross for all NSF transactions, in addition to what your financial institution may charge.

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 www.cdnpay.ca. If the bank account requires more than one signature, all account holders must sign the authorization.

2 ☐ **Annual Cheque** — Attach a cheque for one full year's premium payable to Pacific Blue Cross and sign in step D.

3 ☐ **Credit Card** — ☐ VISA ☐ MasterCard ☐ American Express

Name on credit card

Credit card number

Expiry date (mm/yyyy)

D X Signature of account/credit card holder | Date (mm/dd/yyyy) | X Second account holder signature (if required) | Date (mm/dd/yyyy)

Part 7 Signature of Applicant

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/BC Life 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/BC Life 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 www.pac.bluecross.ca.

Name of Applicant | X Signature of Applicant | Date (mm/dd/yyyy)

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