

Member #

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) THO005 PBC use only: Issued ID
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Part 1 Applicant Information

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Last name		
First name and initial(s)		Birthdate (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> 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	<input type="checkbox"/> M <input type="checkbox"/> F	
Child		mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F	
Child		mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> F	
Child		mm/dd/yyyy	<input type="checkbox"/> M <input type="checkbox"/> 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
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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.)

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

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).

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

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 Signature of account/credit card holder _____ Date (mm/dd/yyyy) _____ 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 _____ Signature of Applicant _____ Date (mm/dd/yyyy) _____