



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



Instructions

- (1) Print in ink or type information.
- (2) Over-age dependent status*:

E = attending college or university
 S = physically or mentally disabled

**APPLICATION FOR
 PERSONAL HEALTH PLAN**

PART I - BASIC INFORMATION

Applicant's Last Name			Language Preference <input type="checkbox"/> English <input type="checkbox"/> French			Occupation						
Applicant's Address Street & No.			OPTIONS® PLUS <input type="checkbox"/> Principal Benefits (Mandatory) If 65 + <input type="checkbox"/> Travel <input type="checkbox"/> No Travel <input type="checkbox"/> Drugs (Optional) <input type="checkbox"/> Dental (Optional) <input type="checkbox"/> Critical Care (Optional) Assured Access†(Optional) <input type="checkbox"/> Pre-Approved Term Life*			COVERAGE			OPTIONS® <input type="checkbox"/> Principal Benefits (Mandatory) <input type="checkbox"/> Drugs (Optional) <input type="checkbox"/> No Deductible <input type="checkbox"/> Deductible <input type="checkbox"/> Dental (Optional) <input type="checkbox"/> Critical Care (Optional) <input type="checkbox"/> Hospital Cash (Optional) Assured Access†(Optional) Pre-Approved Term Life*			
City / Town		Province		† Optional at time of purchase only. *Automatically approved if under age 40 and qualify medically.								
Postal Code		Applicant's Telephone No. (Home)			Requested effective date of Policy: Please begin my coverage on the 1st day of _____ Month _____ Year							
E-mail Address		Applicant's Telephone No. (Business)			Have you had, or do you now have, Medavie Blue Cross coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate: _____			Is this application intended to replace your current Medavie Blue Cross policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		Applicant's Telephone No. (Cellular / Pager)			ID No. _____			Policy No. _____				
First Name	Initial	Surname	Smoker Y/N	Pregnant† Y/N	Sex M/F	Date of Birth DD MM YY			Status* E or S	Height	Weight	Name of Physician
Applicant			00									
Spouse / Cohabitant (as defined in policy)			01									
Children			02									
			03									
			04									
			05									
			06									
			07									
			08									

* Over-age dependant status: E = attending college or university S = physically or mentally disabled
 † Please note that coverage for maternity benefits or conditions arising out of pregnancy are available only after eight (8) months of continuous coverage.

FOR MEDAVIE BLUE CROSS USE ONLY

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

PART II - MEDICAL INFORMATION

Please take the time to read carefully and answer the following questions. Should our post-audit process determine that the responses to these questions did not represent complete and full disclosure, this policy could be cancelled without advance notification.

1. Are you and all listed dependents currently covered by a Provincial Health Plan within Atlantic Canada (Medicare in New Brunswick, Medical Services Insurance in Nova Scotia, Hospital and Medical Services Ins. in Prince Edward Island or Medical Care Plan in Newfoundland)? Yes No

If **no**, please explain _____

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

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

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

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

3. Do you or any listed dependent currently take any prescription medication or have a prescription for which refills are currently authorized? (Please consider all forms of medication, i.e., oral, serums, injections, drops, creams and suppositories.)

Yes No If you answered "yes", please give details:

Person's Name	Prescription Name	Strength	Quantity Taken	Cost/Month	Reason

4. Within the past 2 years, have you or any listed dependent:

- | | | | |
|---|--|--|--|
| a) received treatment from a chiropractor, podiatrist, physiotherapist or psychologist? | <input type="checkbox"/> Yes <input type="checkbox"/> No | c) required orthopedic shoes, orthopedic supplies or arch supports? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) used any ostomy supplies, diabetic supplies, maximist, CPAP or TENS machine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | d) required ambulance services or nursing care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | e) required artificial limbs / prosthesis, braces, walker, wheelchair or oxygen? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

f) required massage therapy, naturopath, acupuncture Yes No

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

5. Do you, or any listed dependent, currently have a referral, testing, treatment, investigation, surgery or appointment contemplated or completed but for which the results have not yet been received? Yes No

6. Within the last 3 years have you or any listed dependent been hospitalized? Yes No
If "yes", please explain the following: Who? Date? Duration? Reason? Name of physician? Result?
7. During the past 3 years, have you or any listed dependent had your driver's license suspended or revoked, been convicted of a) more than 3 driving violations? b) refusing to take a breathalyser? or c) driving while impaired? Yes No If "yes", please give details.
8. In the past 5 years, have you or any listed dependent ever used narcotics (e.g. morphine, heroin), controlled substances (e.g. diazepam, lorazepam), hallucinogens (e.g. LSD, marijuana) or stimulants (e.g. amphetamines, cocaine), **except** as prescribed by a physician? Yes No If "yes", please provide details including type, usual quantity and frequency of use, and date of last usage.
9. Do you or any listed dependent have a physical impairment, disease or disorder not stated above? Yes No If "yes", please give details.

OPTIONS[®] PLUS
Monthly Rate

OPTIONS[®]
Monthly Rate

Mandatory
- Principal Benefits Module

Optional
- Drug Module

- Dental Module

- Critical Care Module

- Assured Access Module

Monthly Total

Mandatory - Principal Benefits Module

Optional - Drug Module

No Deductible

Deductible

- Dental Module

- Critical Care Module

- Hospital Cash Plan Module

- Assured Access Module

Monthly Total

The Drug Module with a deductible is only available with the Options plan.

These rates are subject to approval based on satisfactory evidence of health. Rates are subject to change between the date of application and the policy effective date.

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Signature

Agent's Number

Agent's Telephone Number

**A
G
E
N
T**

Agent's Name (please print)

Agent's Fax Number

Agent's Mailing Address

Agent's e-mail Address

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied.

Accidental death and dismemberment benefits, Life Benefits and Critical Care will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.

AGREEMENT AND CONSENT

I/We, the undersigned, understand and agree that any pre-existing condition/injury or the signs of which that appeared or occurred on or before the date of this application are not covered by this policy. The discovery of facts known by my/our eligible dependents or me/us but not stated on this application could result in the denial of a claim and the cancellation or modification of this policy. I/We further acknowledge that it is my/our responsibility to notify Medavie Blue Cross of any changes in my/our health status or the health of my/our dependents from the date of application until a policy is issued or the effective date, whichever is later. Medavie Blue Cross reserves the right to recover any monies paid on my/our behalf or on the behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this application form. I/We agree to repay to Medavie Blue Cross any and all monies paid as a result of the discovery of facts not fully disclosed on this application.

I/We, the undersigned, declare the answers to the above questions are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my/our policy, to recommend suitable products and services to me/us and to manage the Company's business. I/We authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, organization, institute or person, that has any records or knowledge of me/us or my/our health, to give Blue Cross Life, Medavie Blue Cross or their reinsurer any such information. I/We further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/our personal physician or other medical practitioner. This consent is valid for as long as the contract is in force, unless I/we revoke it in writing. I/We understand I/we may revoke my/our consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I/We understand why my/our personal information is needed and am aware of the risks and benefits of consenting or refusing to consent. I/We can contact Medavie Blue Cross at 1-800-667-4511 should I/we have questions as to the collection, use or disclosure of my personal information.

I/We acknowledge and agree that there is no coverage and that Medavie Blue Cross is not at risk unless a contract comes into effect as a result of this application. This consent complies with federal and provincial privacy laws. *(A photographic copy of this authorization shall be as valid as the original.)*

Dated on this _____ day of _____ year _____

Signature of Applicant _____

Signature of Spouse / Cohabitant _____

(as defined in policy)

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/ our instructions for recurring payments and/or one-time payments from time to time, for payment of insurance premium. Regular monthly payments will be debited to my/ our specified account on the first business day of every month. **Medavie Blue Cross will not provide pre-notification but will provide 30 days notice if the deduction is subject to change.** Medavie Blue Cross will obtain my/ our authorization for any other on-time or sporadic debits. Medavie blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/ us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of service: Personal Business **Please attach a void cheque.** (Credit card payments are not accepted)

Financial Institution (FI): _____ FI Account Number: _____ FI Transit Number: [] [] [] [] [] [] - [] [] [] [] [] []

Address: _____ City/Town _____ Province: _____ Postal Code [] [] [] [] [] []

Authorized Signatures: _____ Date: _____

If someone other than the policy owner will be paying the premium, please have them sign above and complete their personal information below.

Name: _____

Address: _____ City/Town: _____ Province: _____ Postal Code [] [] [] [] [] []

Telephone Number (Business): [] [] [] [] - [] [] [] [] - [] [] [] [] Residence: [] [] [] [] - [] [] [] [] - [] [] [] []

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

Please complete information above and Fax to this number: (902) 865-0590
PLEASE ATTACH A COPY OF YOUR CHEQUE MARKED "VOID".