PACIFIC BLUE CROSS™ BC Life®

BLUE Choice® Individual Plan Application

Mailing Address
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PBC use only: Application #
PBC use only: Issued ID
Broker ID (for Broker/Agent use only)

HOW TO COMPLETE THIS FORM

- Print in ink or type information.
- Only permanent BC residents are eligible for coverage.
- **ALL APPLICANTS** must complete Parts 1, 2, 5 and 6.
- **PART 3: BENEFICIARY DESIGNATION** is not required for Dental Only plans.
- **PART 4: MEDICAL DECLARATION** must be completed if you are applying for a Blue Choice plan. Application must provide a complete medical history of all eligible family members.

Part 1 | Applicant and Dependent Information

Complete Sections **A** and **B** as applicable.

A APPLICANT

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | Last name

First name and initial(s)	Birthdate (mm/dd/yyyy)	Sex ☐ M ☐ F	Care Card #	Ht (inch/cm)	Wt (lbs/kg)

Address (suite/apt/street)	City	Province	Postal code

Home telephone	Work telephone	Cell	E-mail address

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

B DEPENDENTS

Last name	First name and initial(s)	Birthdate (mm/dd/yyyy)	Sex	Care Card #	Ht (inch/cm)	Wt (lbs/kg)
Spouse			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ 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 (19 years of age for Dental Only plan), 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 four dependent children, list them on a separate sheet.

Part 2 | Application for Benefits

Complete first line, choose plan from Sections **A** – **C** and Travel Insurance Add-on **D** if desired.

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

A BLUE CHOICE PLAN ☐ Core Extended Health Care Benefits (required)

OPTIONS ☐ Essential Prescription Drug OR ☐ Enhanced Prescription Drug | ☐ Essential Dental OR ☐ Enhanced Dental

☐ Pay Direct Drug Card — available with Enhanced Prescription Drug option and provided there are no pre-existing conditions (see Part 4)

☐ Healthy Blue Living Program — qualified individuals receive a discount on the Extended Health portion of their coverage. The discount will be applied upon completion of the medical questionnaire review.

B BLUE CHOICE CONVERSION PLAN ☐ Core Extended Health Care Benefits (required)

OPTIONS ☐ Enhanced Prescription Drug — includes Pay Direct 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 #	Group plan #	Benefit ID #/certificate #	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 — I am applying for dental coverage as a supplement to my existing Canadian Blue Cross employer group extended health plan:
☐ Essential Dental OR ☐ Enhanced Dental

Canadian Blue Cross plan	Contract #

D **TRAVEL INSURANCE ADD-ON** ☐ 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, toll-free at 1 800 USE-BLUE (1 800 873-2583) or visit our website at **www.pac.bluecross.ca**.

Part 3 | 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 4 | Medical Declaration Complete Questions 1 – 9.

MUST BE COMPLETED IN FULL IF APPLYING FOR THE BLUE CHOICE PLAN. This declaration is not required for the Conversion Plan or Dental Only Plans.
Based on your family's medical history coverage may be declined or modified to exclude certain conditions or may be given a higher premium. Expenses incurred as a result of current or past conditions may not be covered unless specified in the agreement letter. Additional information may be requested to underwrite your application.

1 Have you or any listed dependent been diagnosed with, treated, prescribed medication, or had any known indication of any condition during the past 12 months?

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

2 Have you or any listed dependent required or used medical equipment in the past 12 months or in the foreseeable future need medical equipment?

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial limbs, braces, walker or cane	☐	☐	Diabetic supplies or equipment	☐	☐	Orthopedic shoes, orthopedic supplies or arch supports
☐	☐	Hearing aid	☐	☐	Ostomy supplies	☐	☐	Ambulance services or nursing care
☐	☐	Wheelchair	☐	☐	Nebulizer	☐	☐	Non-traditional medicinal therapy (Naturopathic or Homeopathic)
☐	☐	Oxygen						

3 Have you or any listed dependent consulted or received treatment from a medical professional in the past two years?

Yes	No		Yes	No		Yes	No	
☐	☐	Physician	☐	☐	Acupuncturist	☐	☐	Chiropodist/Podiatrist
☐	☐	Chiropractor	☐	☐	Massage Therapist	☐	☐	Psychologist
☐	☐	Physiotherapist						

4 Provide details for each **YES** answer given in Questions 1–3 as well as details on any additional physical impairments, disease or disorders that you or your dependents have that are not listed.

Person's name	Illness/condition or equipment specialist	First treatment date (mm/dd/yyyy)	Treatment duration	Treatment type	Treatment results/ extent of recovery	Treatment provider (name/address/phone)

5 Have you or any listed dependent taken any prescription medication for any reason in the last six months or have a prescription for which refills are currently authorized (including oral medication, serum, injection, drops, creams and suppositories)? ☐ Yes ☐ No

If **YES**, provide details below:

Person's name	Prescription name	Strength	Quantity taken	Cost per month	Number of refills per year	Reason

6 Are you or any listed dependent pregnant? ☐ Yes ☐ No

If **YES**, what is the person's name _____ and due date (mm/dd/yyyy) _____

7 Have you or any listed dependent smoked or used tobacco in the last 12 months? ☐ Yes ☐ No

If **YES**, please provide details below:

Person's name	Type of tobacco use	How often (e.g., number of cigarettes per day)

8 During the past five years, have you or any listed dependent used marijuana, cocaine, hallucinogenic or narcotics (e.g., morphine or heroin), sedatives or tranquilizers, except as prescribed by a physician? ☐ Yes ☐ No

If **YES**, indicate person's name(s), type and how often per day _____

9 **APPLICANT DECLARATION (Complete only if NO medical conditions)**

If in the foregoing questions 1–8 you answered **NO** throughout and you and your dependents have no physical impairments, disease or disorders, please confirm by initialing in the box to the right.

Applicant's initials

Part 5 Payment Complete steps A – C as applicable. All must complete step D.

A POLICY SPONSOR INFORMATION (Bank Account/Credit Card Holder, only if different from the Applicant)

Name (last, first)		Home telephone	
Address (suite/apt/street)	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 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

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

Name on credit card	
Credit card number	Expiry date (mm/yyyy)

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

Part 6 Applicant's Signature

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.

Applicant's name	X Applicant's signature	Date (mm/dd/yyyy)

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