Application

BLUE CROSS®

Helpful tips for Completing your Blue Cross Application

The following helpful tips will assist you in completing your application

TIP #1 – CHECKLIST
When completing the application use the checklist located on pages IV and V. This way you will be sure to have completed all the necessary information and ensure the quickest possible processing of your client's application.

TIP #2 – SIGNATURES
Missing signatures are one of the main reasons applications are returned. The enclosed checklist indicates the pages that will require a signature indicated by a .

Be sure to double check that you have all of the signatures.

TIP #3 – ONTARIO AND QUEBEC SYMBOLS
Sections marked with apply to Ontario applicants only and sections marked with apply to Quebec applicants only.

Checklist (Sections to be Completed)

BLUE VISION / BLUE FLEX PRODUCT (EXPRESS PLAN AND GLOBAL PLAN)

	SECTIONS	PAGES	✓
Personal information	1A	3	
If the person to be insured has chosen benefits that include family, couple or single-parent coverage	1C	4	
Policyholder information (If different from Primary Insured)	2	4	
Beneficiary or beneficiaries	3A	5	
Occupation information	4	6	
Effective insurance	5	7	
Method of payment	6.1	7	
Pre-authorized debit (PAD) agreement (To be completed if the person to be insured has chosen the monthly direct debit method of payment)	6.2	8	
Phone interview	7	9	
Declaration	8	10 and/or 11	
To be given to the person to be insured if required: Temporary insurance coverage	9	12	
Authorizations (for the Primary Insured and the spouse if required)	Detachable section	13	
To be given to the person to be insured: Receipt, Notice regarding personal information and Notice regarding medical information (MIB, Inc.) and exchange of information	To be given	14	
For representatives use only	10	15	

MORTGAGE PLAN PRODUCT

	SECTIONS	PAGES	✓
Personal information	1A and 1B	3 and 4	
Policyholder information (If different from Borrower)	2	4	
Beneficiary in case of death	3B	5	
Effective insurance	5	7	
Method of payment	6.1	7	
Pre-authorized debit (PAD) agreement (To be completed if the person to be insured has chosen the monthly direct debit method of payment)	6.2	8	
Phone interview	7	9	
Declaration	8D	11	
Authorizations (for the Borrower and the Co-borrower if required)	Detachable section	13	
To be given to the Borrower: Receipt, Notice regarding personal information and Notice regarding medical information (MIB, Inc.) and exchange of information	To be given	14	
For representatives use only	10	15	

Contract no.

Spouse application no.

APPLICATION NUMBER

Application

TYPE OF APPLICATION

IMPORTANT NOTE

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

☐ Blue Vision (Ontario)
- ☐ Express Plan
- ☐ Global Plan

☐ Blue Flex (Quebec)
- ☐ Express Plan
- ☐ Plan Flex

☐ Mortgage Plan

☐ 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

NOTE **The fields for Last name, First name, Date of birth and Age must be completed prior to printing the application.**

A) PRIMARY INSURED/ BORROWER

LANGUAGE CHOICE

☐ French

☐ English

Last name

First name

Date of birth

DAY | MONTH | YEAR | AGE

Place of birth*

COUNTRY, PROVINCE

Sex ☐ M ☐ F

☐ Non-smoker ☐ Smoker

Civil status

- ☐ Single
- ☐ Married
- ☐ Divorced or Separated
- ☐ Common-law marriage

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

☐ Permanent resident (landed immigrant)

☐ Other (please specify):

Do you accept to receive the offers and newsletters from Blue Cross®?

☐ Yes ☐ No

Note that you can unsubcribe at any time.

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)

B) CO-BORROWER
(To be completed for Mortgage Plan)

Last name _____ First name _____

Sex ☐ M ☐ F Date of birth _____ (DAY) _____ (MONTH) _____ (YEAR) Age _____

_____ (TELEPHONE [HOME]) _____ (TELEPHONE [WORK]) _____ (E-MAIL)

_____ (NAME OF EMPLOYER) _____ (EMPLOYER TELEPHONE) _____ (EMPLOYER/BUSINESS E-MAIL)

_____ (OCCUPATION) _____ (DATE OF HIRING) Number of hours worked _____ (HRS / WEEK)

C) 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 OR BORROWER)

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)

APPLICATION NUMBER

3. BENEFICIARY OR BENEFICIARIES

A) BLUE VISION / BLUE FLEX

☐ Life Express ☐ Accidental death ☐ Term life 65

Benefit(s) payable in case of death of the primary insured

Subject to the provisions of this benefit, the Insurer undertakes to pay the benefit(s) to the beneficiary or beneficiaries designated below in case of death of the Primary Insured.

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

NOTE FOR QUEBEC RESIDENTS ONLY

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.

B) MORTGAGE PLAN (MORTGAGE LIFE ONLY)

BENEFICIARY IN CASE OF DISABILITY

Benefits payable for and on behalf of the totally disabled insured are paid directly to the creditor who must use them to reduce the outstanding balance of the disabled insured's mortgage loan.

Borrower

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

Co-borrower

Last name _____ First name _____

Relationship _____ % of shares _____ ☐ Revocable ☐ Irrevocable

4. OCCUPATION INFORMATION

To be completed only if you wish to apply for disability insurance, monthly indemnity or overhead expenses (Global Plan (Ontario) / Flex Plan (Quebec)).

A) EMPLOYEES, COMPANY OWNERS AND SELF-EMPLOYED

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.

a) When do you want to provide proof of income: ☐ with your application ☐ when you make a claim

b) Are you: ☐ an employee ☐ a company owner ☐ self-employed

c) Do you contribute to: Employment Insurance? ☐ Yes ☐ No

The WSIB (Ontario) / The CNESST (Quebec)? ☐ Yes ☐ No

d) Professional titles or diploma: _____

e) If you have been employed for less than 1 year, please indicate previous occupation (if more than 1 year, indicate "n/a"): _____

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

☐ 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 (individual and/or group insurance) or mortgage disability/life policy, including through your employer?
☐ Yes ☐ No If yes, please complete the following information:

NAME OF PRIMARY INSURED / BORROWER OR CO-BORROWER	COMPANY	TYPE OF CONTRACT (Life, disability (individual and/or group insurance) 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] _____

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 8 and attach a void cheque.

Do you authorize Blue Cross Canassurance to charge the first premium before the assessment of your application?
☐ 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, (CHSA and/or CIC), 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 CHSA and/or CIC without giving me prior notice.

   Desired withdrawal date: _____ (excluding the 29th, 30th and 31st). I have attached a void cheque ☐

   I authorize CHSA and/or CIC 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 CHSA and/or CIC are 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, CHSA and/or CIC 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 CHSA and/or CIC 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, CHSA and/or CIC are 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 **payments.ca**.
7. I understand that CHSA and/or CIC 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 CHSA and/or CIC 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 **payments.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. PHONE INTERVIEW

To optimize the interview process, please indicate in the chart below the best time for a specialist to call you for information about your health and lifestyle. Information obtained during the phone interview is considered confidential information.

Please indicate the phone number you would prefer to be contacted:

TELEPHONE

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2
9 AM–12 PM												
12 PM – 2 PM												
2 PM – 4 PM												
4 PM – 6 PM												
6 PM – 9 PM												

Insured 1: Primary Insured/Borrower Insured 2: Spouse/Co-borrower

Blue Cross will be responsible for the phone interview process directly with your client and **will be accountable for obtaining all medical**.

APPLICATION NUMBER

8. DECLARATION

A) DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT (EXPRESS PLAN)

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 _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

_____ SIGNATURE OF THE PERSON TO BE INSURED

_____ SIGNATURE OF REPRESENTATIVE

8. DECLARATION (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 (if applicable)

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.

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

D) DECLARATION FOR ALL BENEFITS FROM EVERY PRODUCT

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

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age) (Primary Insured or Borrower)	SIGNATURE OF SPOUSE OR CO-BORROWER	SIGNATURE OF REPRESENTATIVE

APPLICATION NUMBER

Temporary Insurance Coverage

TO BE GIVEN TO THE PERSON TO BE INSURED

9. BLUE VISION – GLOBAL PLAN (ONTARIO) / BLUE FLEX – FLEX PLAN (QUEBEC)

EFFECTIVE DATE OF THE TEMPORARY INSURANCE COVERAGE

1. This temporary insurance coverage comes into effect if the following conditions are met:
   a) The initial premium is paid in full when the insurance is purchased.
   b) Based on the application, the person to be insured is an insurable risk at the regular rate according to Blue Cross standards.
2. This temporary insurance coverage is effective as of the latest of the following dates:
   a) The date the duly completed application is signed.
   b) The date on which all underwriting requirements are completed.
3. In case of misstatement or omission that could affect risk assessment before the contract comes into effect, no temporary insurance coverage is provided.

This temporary coverage ends after ninety (90) days or on the day the contract takes effect if within less than ninety (90) days.

Blue Cross reserves the right to terminate this temporary insurance coverage at any time.

Only the following benefits are included in this temporary coverage: Monthly indemnity due to accident, Disability due to accident and Term life 65.

Under this temporary insurance coverage, the Monthly indemnity due to accident benefit is limited to $500/month for a maximum of three months, the Disability due to accident benefit is limited to $1 000/month for a maximum of three months and the Term life 65 benefit is limited to $50 000.

REPRESENTATIVE'S SIGNATURE

DATE [DD/MM/YYYY]

APPLICATION NUMBER

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

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, MIB, Inc., 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 and/or Blue Cross Life Insurance Company of Canada (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, Inc. 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]**

APPLICATION NUMBER

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

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, MIB, Inc., 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 and/or Blue Cross Life Insurance Company of Canada (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, Inc. 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]**

APPLICATION NUMBER

TO BE GIVEN TO THE PERSON TO BE INSURED (PRIMARY INSURED OR BORROWER)

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 and/or Blue Cross Life Insurance Company of Canada 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

on.bluecross.ca

CHIEF PRIVACY OFFICER
ONTARIO BLUE CROSS
185 The West Mall, Suite 610
Etobicoke Ontario M9C 5P1
privacyofficer@ont.bluecross.ca

IN QUEBEC

qc.bluecross.ca

CHIEF PRIVACY OFFICER
QUÉBEC BLUE CROSS
1981, McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
privacyofficer@qc.bluecross.ca

NOTICE REGARDING MEDICAL INFORMATION (MIB, INC.) AND EXCHANGE OF INFORMATION

Information regarding your insurability will be treated as confidential. The Insurer or the Insurer's reinsurers may, however, make a brief report thereon to MIB, Inc., which operates an information exchange on behalf of its members, if you apply for a life or health insurance with another MIB, Inc. insurer member, MIB Inc., on request, will supply such Insurer with the information about you in its files.

All insurers including Canassurance Hospital Service Association, Canassurance Insurance Company and Blue Cross Life Insurance Company of Canada 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, MIB, Inc. 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 the information in the MIB, Inc. files, you may contact them and seek a correction.

MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

infoline@mib.com

"MIB, Inc. 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, Inc. 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, Inc. is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB, Inc. commitment to protect the confidentiality and security of your personal information, you may contact the MIB, Inc. Privacy Department at privacy@mib.com

10. FOR REPRESENTATIVES USE ONLY

A) GENERAL INFORMATION

Important

a) Should the Express Plan benefits be issued on the same date as the Global Plan/Flex Plan benefits?
☐ Yes ☐ No

b) I personally met with the client (applicable only for life insurance). ☐ Yes ☐ No

If the answer is No, please explain why:

c) I provided the Temporary insurance coverage certificate to the client. ☐ Yes ☐ No

d) In order to allows us to do a complete evaluation, please provide any additional information that you think may assist in the evaluation. If necessary, please provide details or directives for the completion of the application.

BLUE CROSS®

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