INDIVIDUAL PLANS APPLICATION FORM

Mailing Address
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Vancouver BC V6B 4E1

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4250 Canada Way
Burnaby BC

Phone 604 419-2200
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Broker ID
LON 012
(for Broker/Agent use only)

Part 1 APPLICANT

Last name	First name	Initial	Date of birth (yyyy/mm/dd)	❑ Male ❑ Female
Address	City	Province	Postal code	Ten digit area code and phone number
E-mail address	S.I.N. (or PBC will issue an ID number)	British Columbia Care Card number(mandatory)		

Part 2 SPOUSE (List only if applying for coverage)

Last name	First name	Initial	Date of birth (yyyy/mm/dd)	❑ Male ❑ Female
E-mail address	S.I.N.	British Columbia Care Card number (mandatory)		

Part 3 DEPENDENTS (List only if applying for coverage)

Child's last name	First name	Initial	Date of birth (yyyy/mm/dd)		British Columbia Care Card number(mandatory)
				❑ Male ❑ Female	
				❑ Male ❑ Female	
				❑ Male ❑ Female	
				❑ Male ❑ Female	
				❑ Male ❑ Female	

Spouse means your legal spouse, or a common-law spouse with whom you have been living continuously 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. Please list children you wish to be covered from oldest to youngest order. If you have more than five dependent children, please list them on a separate sheet.

Part 4 APPLICATION FOR BENEFITS Check (✔) all boxes that apply

(please refer to accompanying rate sheet/FAQ for more information and plan rates)

I/We are applying for ❑ Single ❑ Couple ❑ Family coverage. Coverage to begin on the first day of ____________________ (mm/yyyy)

FIRST CHOICE Plans

❑ **Health**

❑ **Health and Dental**

❑ **Dental Add-on:** I am applying for Dental Coverage as a supplement to my existing Canadian Blue Cross employer group extended health plan. **Please provide plan information below.***

❑ **Dental Only**

DELUXE CHOICE Plans

❑ **Health**

❑ **Health and Dental**

❑ **Dental Add-on:** I am applying for Dental Coverage as a supplement to my existing Canadian Blue Cross employer group extended health plan. **Please provide plan information below.***

BLUE CHOICE Plans**

❑ **Health** - 64 Years & Younger
❑ **Health** - 65 Years & Over

Optional Add-ons to Blue Choice

❑ **Enhanced Drug Coverage** *for 64 years and younger*
❑ **Nursing and Rehabilitation**
❑ **Dental Plan A**
❑ **Dental Plan A and Plan B**
❑ **Direct-Pay Drug Card** *(See pre-existing medical conditions - Part 8)*

❑ **I am applying for conversion privileges.** *(Please read and complete Part 5).*

****Conversion privileges do not apply for our Blue Choice Plans**

***I am applying for Dental Add-on coverage.** My existing Canadian Blue Cross group Extended Health coverage is with

______________________________ Canadian Blue Cross Plan

______________________________ Policy Number

Part 5 PLAN CONVERSION APPLICATION

Applicants who were or are currently covered by a Canadian Blue Cross employer group plan may be eligible to convert their coverage to a FIRST CHOICE or DELUXE CHOICE Individual plan.

We will cover pre-existing conditions under our extended health plans and waive the three month *no claims waiting* period on our dental plans provided that:

- You (and your family members, if applicable) were covered under a Canadian Blue Cross employer group plan for the same benefits *e.g. dental and/or extended health* for at least six continuous months and
- We receive your application within 60 days of the date your group coverage terminated

You will be billed from the first day of the month following the termination date of your group plan. No lapse in coverage is permitted.

Previous Pacific Blue Cross(PBC)/Canadian Blue Cross group plan information:

Group number ________________ ID number _______________________ Termination date(yyyy/mm/dd)___________________

Benefits included under this plan: ❑ Extended Health ❑ Vision Care ❑ Dental ❑ Dentures

Part 6 OTHER COVERAGE

I and/or my spouse had extended health and/or dental coverage with the following private insurance carrier(s), on a group basis (provided by an employer, past or present) or on a personal basis (individual plan).

Insurance Carrier: ___________________________ Plan: ❑ Group ❑ Individual _____________________ _____________________

Province Policy number

Part 7 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 of the following conditions 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 privilages (see Part 5.)

Categories

Condition	Applicant	Spouse	Dependent
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)	❑	❑	❑
Hernia or bowel disorder	❑	❑	❑
Bone or joint disorder (including arthritis or rheumatism)	❑	❑	❑
Mental, nervous or emotional disorder. (including depression or anxiety), Attention deficit hyperactive disorder	❑	❑	❑
Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)	❑	❑	❑
Reproductive system disease or disorder or infertility	❑	❑	❑
Chronic headaches or migraine headaches	❑	❑	❑
Skin disease or disorder (including acne)	❑	❑	❑
Neurological disorder, seizures, multiple sclerosis or paralysis	❑	❑	❑
Cancer, tumor or leukemia	❑	❑	❑
Diabetes, colitis, or Crohn's disease	❑	❑	❑
Chest and heart conditions	❑	❑	❑
High blood pressure, stroke, blood disorder or elevated cholesterol	❑	❑	❑
Alcohol or drug dependency	❑	❑	❑

If you, or any of your dependents have a physical impairment, disease, or disorder listed or not listed above, please provide details.

Person's name	Specific illness or condition	Name, address or phone number of physician, provider or hospital providing treatment	Type of treatment received/prescribed	Dates and/or duration of treatment

❑ **N/A - I/We have no pre-existing medical conditions. Please initial _________**

Part 8 BLUE CHOICE Plans Direct Pay Drug Card

A direct pay drug card is available with the BLUE CHOICE plans *for those who qualify* and would like the convenience of a card. We will determine whether to issue a direct pay drug card on the basis of your completed application. We will decline to issue a card if you or your dependents are taking medications for a pre-existing condition. If further information is required from your physician to make this determination we will reimburse you directly for the cost of obtaining this information up to a maximum of $40.

We require a copy of your PharmaNet patient record for all covered persons within 30 days of your application for a direct pay drug card. You can request a copy of this record from your local pharmacy. This is done online by your pharmacist. This PharmaNet record lists all of your prescriptions filled at PharmaNet-connected pharmacies in the past 14 months and is confidential.

We will process your application when we receive it. Mail the PharmaNet patient record to Pacific Blue Cross, Individual Products Department, for our review. We will keep this record and information confidential.

We will mail you identification cards once the approval process is complete. If we decline to issue you a card we will rebate that portion of any premium amount paid by you for the card and update your contract application and receipt information.

Part 9 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 First Choice or Dental Only Plans)

APPLICANT				SPOUSE			
Beneficiary's full legal name	Relationship	%	Trustee's full legal name	Beneficiary's full legal name	Relationship	%	Trustee's full legal name
Beneficiary's full legal name	Relationship	%	Trustee's full legal name	Beneficiary's full legal name	Relationship	%	Trustee's full legal name

Part 10 PAYMENT OPTIONS

Check (✔) all boxes that apply and provide applicable information.

I would like to pay ❑ **Monthly** on the first day of each month

❑ My initial cheque in the amount of $________ payable to Pacific Blue Cross for pre-authorized withdrawal from a bank account is attached. *Please provide details below.*

❑ My credit card details are below

I would like to pay ❑ **Annually**

❑ My cheque for a full year's premium in the amount of $ ________ payable to Pacific Blue Cross is attached.

❑ My credit card details are below. Amount $ ____________

Credit Card Information

❑ VISA ❑ MasterCard

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

Pre-authorized payment information

I authorize my bank/financial institution to allow Pacific Blue Cross/BC Life to withdraw monthly payments from my account beginning the 1st of ____________ (mm/yyyy). In my first year of coverage, each monthly payment will be $ ________ . Thereafter, the monthly payment amount may change for each subsequent 12 month period effective on the anniversary date of my plan. Unless I instruct otherwise, Pacific Blue Cross/BC Life will be authorized to withdraw the relevant amount each month.

Name of bank/financial institution and full address of branch:

Branch #: ____________ Institution #: ____________ Account #: ____________ Telephone: ____________ (ten digits)

Signature(s) of account holder(s): ______________________ ______________________

Part 11 SIGNATURE OF APPLICANT/POLICY HOLDER

I have read this application and certify that all questions are answered fully and correctly.

I am actively enrolled in all applicable Government plans.

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 policy.

I authorize Pacific Blue Cross/BC Life to use social insurance numbers for identification purposes only.

I understand that any information provided by me in relation to this contract, or any other contract with Pacific Blue Cross(PBC) or a Blue Cross organization, may be used by Pacific Blue Cross in adjudicating claims for me and my dependents.

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 PBC. This includes my health records and the health records of my covered dependents, and details of coverage eligibility.

Signature of applicant: ______________________ Date: ____________ (yyyy/mm/dd)

If the applicant is under 19 years, you must designate an adult as the policy holder.

Signature(s) of policy holder(s): ____________ ____________ ____________

Name of policy holder **Signature** **Date (yyyy/mm/dd)**

Application must be submitted by mail. PBC cannot process faxed copies.

Part 12 OPTIONAL INFORMATION

Help us assess your needs and allow Pacific Blue Cross to serve you better. All the information you provide will be kept strictly confidential and will not be distributed for uses other than those stated in this application form.

How did you hear about Pacific Blue Cross?

❑ Newspaper article/ad ❑ Magazine article/ad ❑ Radio program/ad ❑ TV program/ad
❑ Doctor ❑ Word of mouth ❑ Community or business event
❑ Dentist ❑ Other ______________________________

Tell us about yourself.

What is your position in the family? ______________________________

Your height ______________ Your current weight ______________

Do you wear corrective lenses? ❑ glasses ❑ contact lenses

Do you or a member of your family have a disability? ❑ yes ❑ no

How many are there in your household? Adults _____ Children _____ Elderly relatives _____

How many vehicles? ______________

Do you ❑ own or ❑ rent your current residence? For how many years? ____________

What is your profession?

❑ Medical professional ❑ IT professional ❑ Law professional ❑ Teaching professional
❑ Proprietor ❑ Entrepreneur ❑ Industry ❑ Farming
❑ Military ❑ Student ❑ Retired ❑ Homemaker
❑ Management ❑ Other ______________________________

Which credit cards do you own?

❑ MasterCard ❑ VISA ❑ American Express ❑ Diners Club

❑ Department store credit cards ______________________________

What are your activities and interests?

❑ Raquet sports ❑ Wines ❑ Crafts ❑ Reading Books
❑ Golf ❑ Gourmet Cooking ❑ Stamps/Collecting ❑ Household Pets
❑ Snow Skiing/Boarding ❑ Running ❑ Gardening ❑ Furnishing/Decorating
❑ Camping/Hiking ❑ Reading ❑ Physical Fitness ❑ Cultural/Arts
❑ Fishing ❑ Health/Natural Foods ❑ Fashion/Clothing ❑ Boating/Sailing
❑ Photography ❑ Surfing the Internet ❑ Swimming/Diving ❑ Team Sports
❑ North America Travel ❑ Other Travel which countries? ______________________________

Your reading interests?

❑ Business ❑ Travel ❑ Technology/Computers ❑ Food/Cooking
❑ Sports ❑ Crafts ❑ Entertainment ❑ Fiction
❑ Health/Fitness ❑ History ❑ Auto Mechanics ❑ Science Fiction
❑ Romance ❑ Political/Current Affairs ❑ Sciences ❑ Furnishing/Decorating
❑ Celebrities ❑ Architecture ❑ Home Building ❑ Remodelling
❑ Other ______________________________

Do you know anyone who would appreciate information about our products? If so, please indicate:

❑ Health ❑ Dental ❑ Travel ❑ Visiting Canada

Name ______________________________ Phone number ______________________ (ten digits)

Address ______________________________ Postal code ______________________

™ Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society is an independent licensee of the Canadian Association of Blue Cross Plans.
® BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly–owned subsidiary of Pacific Blue Cross.

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