PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BUSINESS SELECT® EMPLOYER APPLICATION

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2199 | pac.bluecross.ca

	Broker ID	Policy number (office use)

PART 1 — EMPLOYER INFORMATION (Policy holder)

Registered name of employer

Address	City	Province	Postal code

Name of administrator	Title

Telephone (ten digits)	Fax (ten digits)	Email

Nature of business	Years in business

Subsidiaries or affiliated companies to be included

Number of eligible employees	Number of employees to be covered	Amount paid with application

PART 2 — APPLICATION FOR BENEFITS

❑ Business Select Plan

Optional add-ons to Business Select:

❑ Nursing and Rehabilitation or ❑ Dental Plan A or ❑ Dental Plan A and Plan B

PART 3 — RATES AND OPTION SELECTIONS

	Rates		Number of Subscribers		
Single rate		x		=	$0.00
Couple rate		x		=	$0.00
Family rate		x		=	$0.00
			Total Monthly Contributions:		$0.00

Name of Group (office use)	Policy number (office use)

Enrolment requirements

All eligible employees including owners and managers must enroll for each benefit unless they are already covered through their spouse's plan. Eligible employees must work a minimum of 20 hours each week on a full-time permanent basis.

Employer contribution

The employer portion of the contribution will be considered an operating expense and may provide tax advantages for your business. Contributions can be made up to 100% of the cost.

Pre-authorized payment plan

As this plan uses pre-authorized payment plan, we will require the first month's premium and a voided cheque for future single monthly premium withdrawals from the company.

Termination of coverage

All benefit coverage ceases when the employee reaches the age of 75.

Premium rates

The accepted premium rates will not change for a period of at least 12 months from the agreed effective date of the group coverage.

Pre-existing medical conditions

Our benefits do not cover claims associated with pre-existing medical condition(s) that existed at any time during the 12 months before joining the plan.

Pacific Blue Cross Fee Schedule

We pay for eligible dental and denturist services according to the applicable Pacific Blue Cross Fee Schedule. This schedule lists eligible dental services, treatment frequency limits and fees. Your Dentists or Denturists will have a copy of the Pacific Blue Cross Dental Fee Schedule. Any fees in excess of the Fee Schedule are your responsibility. Pacific Blue Cross will reimburse you or will pay your dentist directly.

For services performed by a dental specialist, we will pay up to 10% over the amount of the Pacific Blue Cross Fee Schedule or the current specialist fee guide, whichever is lower.

Spouses and newborns

Spouses through legal marriage and newborns are added to your coverage if an application with appropriate payment is received with 60 days of marriage or birth. If the application is submitted after the 60 days, we will consider this a late application.

Only one spouse may be covered at one time under your plan. A common-law spouse is eligible for coverage under your plan after a cohabitation period of at least 12 months.

PART 4 — EFFECTIVE DATE

It is understood and agreed that no coverage shall take effect until:

1) this application has been accepted and the effective date approved by PBC,
2) PBC has received payment of the estimated first month's billing, and
3) 100% of eligible employees have applied for coverage.

Name of agent / consultant

PART 5 — PAYMENT METHOD (Choose one method below)

POLICY SPONSOR INFORMATION Bank account/credit card holder, only if different from the Applicant

First name	Last name	Daytime phone number (10 digits)	
Street address	City	Province	Postal code

PAYMENT FREQUENCY ☐ Monthly ☐ Annually — in the amount of: $ _____

☐ **Pre-authorized debit (PAD)** — Attach a cheque marked VOID or a pre-authorized payment form provided by your bank that identifies your branch and account information. This will only apply to the payment being withdrawn from your banking account (PAD). If you wish to change your banking information to receive claims payments in that same account, please contact us. The only frequency available for PAD is monthly. Pre-authorized payment account type: ☐ Business ☐ Personal.

☐ **Annual cheque** — Attach a cheque for one full year's premium payable to Pacific Blue Cross.

☐ **Credit card** — In accordance with Payments Canada safety and privacy regulations, we collect *only* the last four (4) digits of your credit card number. DO NOT write your full credit card number on this application form.

☐ Visa ☐ Mastercard ☐ American Express

Name on card _____ Last four (4) digits of credit card: _____ Expiry date (mm/yy): _____ / _____

Once we receive your application form, we will contact you to obtain your additional credit card information required for payment.

PART 6 — AUTHORIZATION

I (We) authorize PBC to make deductions, from the credit card or 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 Member'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 PBC to notify me (us) of this authorization before the first payment is processed and any subsequent monthly regular payment.

The withdrawal amount is considered variable under the Payments Canada rules. PBC 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 Member's most recent address that PBC has on record at the time a notice is sent. All persons, whose signatures are required to sign on this account, have signed this authorization.

Pacific Blue Cross may terminate coverage, or change the method of payment with written approval of the Policy Sponsor to another qualifying method, should a withdrawal be refused for any reason. Pacific Blue Cross will charge a fee for any withdrawal that is not honoured.

I (We) will notify PBC in writing of any changes in the account information or termination of this authorization within ten (10) business days prior to the next debit. 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 payments.ca.

Account/card holder's signature	Second account/card holder's signature (if required)	Date (mm-dd-yyyy)
X	X	

PART 7 — APPLICANT 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 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 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 pac.bluecross.ca.

Applicant's signature	Applicant's full name (print)	Date (mm-dd-yyyy)
X	X	