PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

APPLICATION FOR INDIVIDUAL ENHANCED CRITICAL ILLNESS

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

- **APPLICANTS — Please ensure this application is completed in full. Only complete PART 3 if you wish to include a Child Critical Illness Benefit Rider. Please return completed applications to the address above.**
- Print in ink or type information.

OFFICE USE ONLY

Application number	ID number	Broker ID (for Broker/Agent use only)	QUOTE NUMBER (4 digits)

PART 1 — APPLICANT AND OWNER

☐ Mr. ☐ Mrs. ☐ Ms.	First name	Last name	Middle initial

Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F	Marital status	Occupation

Street address	City	Province	Postal code

Daytime phone number (10 digits)	Home phone number (10 digits)	Email address	How do you prefer to be contacted? ☐ Daytime phone ☐ Home phone ☐ Email

Height	Weight	Smoker status ☐ Smoker ☐ Non-smoker*	* In the past 12 months, you have not used any form of tobacco, nicotine or smoking cessation products, marijuana, nicotine replacement products (i.e. vaping).

Do you currently reside in Canada? ☐ Yes ☐ No	If yes, province of residence	Country of birth	State/province of birth

Are you currently a Pacific Blue Cross Group Plan Member or an Individual Health and Dental Plan Member?* ☐ Yes ☐ No
If yes, please provide your Pacific Blue Cross Policy number and ID number.

Policy number	ID number	* Existing members may qualify for preferred member pricing.

PART 2 — COVERAGE INFORMATION

Coverage amount applying for:
$_____ Must be increments of $25,000 and up to a maximum of $1,000,000

Additional benefits riders:
☐ Waiver of premium ☐ Return of premium upon expiry ☐ Child critical illness

Policy term
☐ 10 year term, renewable to age 75
☐ 20 year term, renewable to age 75
☐ Term to age 75

PART 3 — CHILD(REN) TO BE COVERED

Required only if child critical illness benefit rider has been elected. Please provide the information requested in the table below.

	FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	HEIGHT	WEIGHT
First child				(mm-dd-yyyy)	☐ M ☐ F		
Second child				(mm-dd-yyyy)	☐ M ☐ F		
Third child				(mm-dd-yyyy)	☐ M ☐ F		
Fourth child				(mm-dd-yyyy)	☐ M ☐ F		
Fifth child				(mm-dd-yyyy)	☐ M ☐ F		

PART 4 — BENEFICIARY DESIGNATION

If you do not nominate a beneficiary, these benefits will be paid to you or in the event of your death, it will be paid to your estate. If you make an error, sign or initial beside the correction. If share of proceeds for multiple beneficiaries is not indicated, the share will be split evenly between the listed beneficiaries.

Full legal name	Relationship to you	Share of proceeds %
Full legal name	Relationship to you	Share of proceeds %

Applicant trustee designation — Complete only if a beneficiary is under age 18
I hereby appoint as trustee to receive from British Columbia Life & Casualty Company any amount which may be due to my beneficiary, while the beneficiary is a minor.

Full legal name	Relationship to you

PART 5 — APPLICANT FINANCIAL INFORMATION

What is your annual earned income, including salary, commissions and bonuses? _____

What is your annual unearned income from other sources, including pensions, dividends, interest, and income from real estate? _____

Have you declared or been petitioned into personal or corporate bankruptcy? ☐ Yes ☐ No

If you are financially dependent on your spouse, please provide the following information on the income earner:

Spouse annual earned income: _____ Spouse unearned income: _____

Do you or your dependents now have, or are applying for, other life, critical illness or disability income insurance? ☐ Yes ☐ No

If yes, type of insurance: _____ Amount: $ _____

PART 6 — PURPOSE OF INSURANCE

Please select all that apply

☐ Income replacement
☐ Funeral expenses
☐ Savings protection
☐ Insure children
☐ Mortgage and loan protection
☐ Unemployed
☐ Other _____

PART 7 — GENERAL DECLARATION

Please provide the information requested in the table below.

1a. Have you used any form of tobacco, tobacco cessation products, marijuana, nicotine or nicotine replacement products in the last 12 months? ☐ Yes ☐ No If yes, please provide details: _____

2. In the past 12 months have you, or any of your dependents, had any weight changes? ☐ Yes ☐ No If yes, please provide details.

Applicant	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason
Child(ren)	☐ Gained ☐ Lost	_____ ☐ lbs ☐ kg	Reason

	APPLICANT	CHILD(REN)
3. Have you or your dependents ever applied for or received benefits, compensation or pension due to sickness or injury?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you or your dependents been absent from work because of sickness or injury during the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you or your dependents had a request for life, critical illness, disability or health insurance declined, postponed, rated, or restricted in any way?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, provide details: _____

PART 8 — APPLICANT PHYSICIAN INFORMATION

Do you have a regular physician? ☐ Yes ☐ No	Physician's name	Physician's phone number

Physician's address

Last date of visit (mm-dd-yyyy)	How long have you been a patient of this regular physician?
Reason for last visit to regular physician	Result of last visit to regular physician

In the last 5 years, have you seen a physician who is not your regular physician?

☐ Yes ☐ No If yes, provide details including their name, contact information and purpose of visit:

PART 9 — CHILD PHYSICIAN INFORMATION

This section is only required if child critical illness benefit rider has been elected.

Do you have a regular physician? ☐ Yes ☐ No	Physician's name	Physician's phone number
Physician's address		

Last date of visit (mm-dd-yyyy)	How long have you been a patient of this regular physician?
Reason for last visit to regular physician	Result of last visit to regular physician

In the last 5 years, have you seen a physician who is not your regular physician?
☐ Yes ☐ No If yes, provide details including their name, contact information and purpose of visit:

PART 10 — LIFESTYLE INFORMATION

	APPLICANT	CHILD(REN)
Travel and foreign residency		
1. Have you travelled or resided outside of Canada or the United States in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you plan to travel or reside outside of Canada or the United States in the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you plan to change your country of residency in the next 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
If yes to any of the above, provide details including name and time spent in each country and trip purpose:		
Criminal offenses		
1. Have you ever been charged with or convicted of a criminal offence, or is a criminal charge pending?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide details:		
Drugs and alcohol		
1. In the last 10 years, have you used any of the following except as prescribed by a licensed physician or other medical practitioner: Cocaine, narcotic, amphetamine, heroin, ecstasy, hallucinogen, opiate, tranquilizer or similar drug, or other controlled substance?	☐ Yes ☐ No	☐ Yes ☐ No
OR		
Tobacco products (cigarettes, chewing tobacco, snuff and nicotine replacement products)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you consume alcoholic beverages?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide the number of drinks consumed weekly: Beer _____ Wine _____ Liquor _____		
3. Have you ever decided to or been advised to decrease or stop your consumption of alcohol or drugs; or been treated for or been advised to join or joined an organization because of alcohol or drug use?	☐ Yes ☐ No	☐ Yes ☐ No
If yes to question 3, provide details:		
Driving		
1. In the last 10 years have you been convicted of or pled guilty to any driving violations, including impaired, careless, reckless, or negligent driving, or had your driver's license revoked or suspended (Excluding parking)?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide details:		
Hazardous sports		
1. Have you engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hang gliding or have you flown in an aircraft other than as a fare-paying passenger?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide details:		

PART 11 — MEDICAL DECLARATION

1. Have you or your dependents ever consulted a physician or practitioner because of, suffered from, been treated for or had any indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your physician.

	APPLICANT	CHILD(REN)
• **Chest or heart conditions** Including circulatory, heart or vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke), blood and lung disorders. Chest pain, irregular pulse, bypass or angioplasty, abnormal ECG, palpitations, swollen ankles, heart murmur, blood clot, pacemaker, shortness of breath, high cholesterol, high blood pressure, congestive heart failure, valve disorders, neuropathy, aneurysm, transient ischemic attack (TIA), peripheral vascular disease (poor circulation).	☐ Yes ☐ No	☐ Yes ☐ No
• **Diabetes and gland disorders** Including diabetes (IDDM-Type 1) or (NIDDM-Type 2), hormonal or thyroid conditions. Goiter, anemia, abnormal blood sugar, hemophilia, bleeding disorder, abnormality of the thyroid, pituitary, lymph or adrenal gland.	☐ Yes ☐ No	☐ Yes ☐ No
• **Gastrointestinal conditions** Including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), colitis, Crohn's disease, irritable bowel syndrome, diverticulitis, colon polyps, ulcers, hernia, GERD (acid reflux or persistent heartburn).	☐ Yes ☐ No	☐ Yes ☐ No
• **Respiratory or lung conditions** Including allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD). Optic neuritis, loss of speech, asthma, visual disturbance, emphysema, blindness, tuberculosis, recurrent bronchitis, sarcoidosis, spitting of blood, cystic fibrosis, tinnitus, persistent hoarseness or cough.	☐ Yes ☐ No	☐ Yes ☐ No
• **Musculoskeletal conditions** Including osteoarthritis or rheumatoid arthritis, osteoporosis, bone density loss or back, neck, limb or joint or muscle pain (including fibromyalgia). Rheumatism, fibromyalgia, muscular dystrophy, gout, chronic fatigue, rheumatoid arthritis, paralysis, chronic pain, amputation, osteoarthritis or any other type of arthritis, multiple sclerosis, systemic lupus erythematosus (sle) or lupus in any form.	☐ Yes ☐ No	☐ Yes ☐ No
• **Immunological conditions** Including acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or any other immunological disorder, or any positive test results indicating exposure to the AIDS virus.	☐ Yes ☐ No	☐ Yes ☐ No
• **Genitourinary conditions** Including kidney, bladder, infertility or reproductive disorders, menopause, endometriosis, sexually transmitted disease(s) or recurring infections (cold sore/herpes/shingles).	☐ Yes ☐ No	☐ Yes ☐ No
• **Neurological/nervous conditions** Including alzheimer's, dementia, parkinson's, epilepsy, multiple sclerosis, seizures, paralysis, chronic headaches or migraines, or chronic fatigue syndrome. Cerebral palsy, huntington's chorea, fainting, autism, dizziness, loss of balance, cognitive impairment, stroke, loss of speech, muscle weakness, tremor, loss of sensation, tingling, developmental disorder, weakness of the extremities, transient ischemic attack (tia), motor neuron disease, including but not limited to amyotrophic lateral sclerosis (ALS) or lou gehrig's disease.	☐ Yes ☐ No	☐ Yes ☐ No
• **Mental health conditions** Including anxiety, depression, emotional disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD). Panic attack, schizophrenia, mental impairment, bipolar disorder, burnout, attempted suicide or suicidal thoughts.	☐ Yes ☐ No	☐ Yes ☐ No
• **Cancer** Including tumors, leukemia, polyp, basal cell carcinoma, cysts or lumps, malignant melanoma, dysplastic nevi syndrome, enlarged lymph nodes, irregular shaped moles or lesions that have changed in appearance, fibrocystic disease, abnormal biopsy, mammogram or breast ultrasound.	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you or your dependents had any physical impairments, deformities, hospitalization or illness not covered in question 1? If yes, provide details in Question 4.	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you aware of any symptoms or complaints for which you, or your dependents, have not yet consulted a physician or received treatment? If yes, provide details in Question 4.	☐ Yes ☐ No	☐ Yes ☐ No

4. If yes to questions 1 – 3, please give details:

NAME	CONDITION/ DISORDER	DIAGNOSIS DATE	RECOVERY DATE	MEDICATION/TREATMENT	PHYSICIAN NAME, ADDRESS AND PHONE NUMBER
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		
		(mm-dd-yyyy)	(mm-dd-yyyy)		

	APPLICANT	CHILD(REN)
5. Are you or your dependents taking any prescribed medication? If yes, provide name of medication(s) and reason for use in space provided below.	☐ Yes ☐ No	☐ Yes ☐ No

NAME	NAME OF MEDICATION	DOSAGE	FREQUENCY

	APPLICANT	CHILD(REN)
6. Have any of your immediate family members had heart disease, heart attack, high blood pressure, polycystic kidney disease, familial polyposis of the bowel, stroke, diabetes, cancer (specify type below), multiple sclerosis, huntington's chorea, alzheimer's, parkinson's, ALS (Amyotrophic Lateral Sclerosis) or any hereditary disease? If yes, please complete your family's medical history (parents, brothers, sisters) below. If you are applying with any dependents, please provide information about your spouse's family medical history.	☐ Yes ☐ No	☐ Yes ☐ No

FAMILY MEMBER	DETAILS OF ANY DISORDER (INCLUDING AGE OF DIAGNOSIS)	CAUSE AND AGE OF DEATH (IF APPLICABLE)

PART 12 — PAYMENT METHOD (Choose one method below)

POLICY SPONSOR INFORMATION Bank account/credit card holder, please provide contact information 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 13 — PAYMENT AUTHORIZATION

I (We) authorize Pacific Blue Cross 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 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.

The withdrawal amount is considered variable under the Payments Canada rules. 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. 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 Pacific Blue Cross 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 14 — AUTHORIZATION AND SIGNATURE

I confirm that the information I have provided is true and complete.

I understand and consent that some of the personal information provided by me 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 coverage. I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health to give to Pacific Blue Cross, or its reinsurers, any such information. This also includes my health records and the health records of my covered dependents (if applicable), and details of coverage eligibility. I understand that although information regarding my insurability will be treated as confidential, I also authorize that Pacific Blue Cross, or its reinsurers, to make a brief report of my personal health information to MIB.

I also understand and consent to the retention, use and disclosure of this personal information in accordance with Pacific Blue Cross' privacy policy.** A copy of the 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	

PART 15 — MIB PRE-NOTICE

IMPORTANT: Please read carefully.

MIB is a not-for-profit membership organization of insurance companies, including Pacific Blue Cross, which operates an information exchange on behalf of its Members to prevent and detect fraud. You can find further information about MIB by visiting its website at www.mib.com.

Upon receipt of a request, MIB will arrange to disclose to you your personal information MIB has in its file. If required, you may contact MIB to seek a correction of the accuracy of your personal information. MIB's Canadian address is: **MIB, Inc. 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7**. Their phone number is: **(416) 597-0590**.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, you understand that MIB, upon request, will supply such company with your personal information in its file. MIB receives personal information about Canadian consumers and the collection, use and disclosure of such personal information is governed by the Personal Information Protection and Electronic Documents Act ("PIPEDA") and provincial laws. MIB has agreed to protect such information in a manner that is substantially similar to the privacy and security practices of MIB's Canadian member companies, and in accordance with applicable laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. An individual's consumer file at MIB may be accessible to U.S. law enforcement and U.S. national security authorities for anti-terrorist and clandestine intelligence investigations; provided that such authorities comply with the consumer privacy protections specified in applicable U.S. laws.

Pacific Blue Cross may also release your personal information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.