PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BUSINESS SELECT® INDIVIDUAL PLANS APPLICATION

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

☐ New applicant ☐ Reinstatement	I/we are applying for ☐ Single ☐ Couple ☐ Family coverage	Coverage will begin on this date (mm-dd-yyyy)

PART 1 — APPLICANT

☐ 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

BC Services Card number (mandatory)	Company name

PART 2 — SPOUSE (Only if applying for coverage)

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

Is your spouse an employee? ☐ Yes ☐ No	Sex ☐ M ☐ F	Birthdate (mm-dd-yyyy)	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

BC Services Card number (mandatory)	Company name

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	BC SERVICES CARD NUMBER
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	

*** For additional dependents, please attach a separate piece of paper.** 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, 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 — 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).

Select one ☐ Group ☐ Individual	Carrier	Province	Policy number

PART 5 — 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 Pacific Blue Cross any amount which may be due to my beneficiary, while the beneficiary is a minor.

Full legal name	Relationship to you

PART 6 — MEDICAL DECLARATION

1. Have you, your spouse 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	SPOUSE	CHILD(REN)
• AIDS, ARC (AIDS related Complex), positive HIV test or any other immunological disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Hepatitis B, C or B carrier state	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Stomach, intestinal, liver, kidney or bladder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Hernia or bowel disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Bone or joint disorder (including arthritis or rheumatism)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Mental, nervous or emotional disorder (including depression or anxiety), Attention deficit hyperactive disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Reproductive system disease or disorder or infertility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Chronic headaches or migraine headaches	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Skin disease or disorder (including acne)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Neurological disorder, seizures, multiple sclerosis or paralysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Cancer, tumor or leukemia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Diabetes, colitis, or Crohn's	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Chest and heart conditions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• High blood pressure, stroke, blood disorder or elevated cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Alcohol or drug dependency	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Other (please provide details below)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

☐ Not available — I/we have no pre-existing medical conditions. Please initial _____

PART 7 — 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	