PACIFIC BLUE CROSS®

INDIVIDUAL PLAN DECLARATION OF INSURABILITY

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

Phone 604 419-2200
Toll-free 1 800 USE-BLUE
Fax 604 419-2199

inhealth@pac.bluecross.ca
pac.bluecross.ca

PBC use only: Issued ID
Broker ID (for Broker/Agent use only)

Please complete all fields where applicable. Incomplete information may delay the processing of your form.

PART 1 — MEMBER AND NEW DEPENDENT INFORMATION

A MEMBER

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Last name			First name and initial(s)
Birthdate (mm/dd/yyyy)	Sex ☐ M ☐ F	Member ID #	Group #	Policy #

B NEW DEPENDENT INFORMATION

Last name	First name and initial(s)	Birthdate (mm/dd/yyyy)	Sex	Care Card #	Ht (inch/cm)	Wt (lbs/kg)
Spouse			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ M ☐ F			
Child			☐ M ☐ F			

Spouse means your legal spouse, or a common-law spouse with whom you have been continuously living 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. If you have more than four dependent children, list them on a separate sheet.

PART 2 — MEDICAL DECLARATION

MUST BE COMPLETED IN FULL.
Based on your family's medical history coverage may be declined or modified to exclude certain conditions or may be given a higher premium. Expenses incurred as a result of current or past conditions may not be covered unless specified in the agreement letter. Additional information may be requested to underwrite your application.

1 Have any of the listed dependent(s) been diagnosed with, treated, prescribed medication, or had any known indication of any condition during the past 12 months?

Yes	No	
☐	☐	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)
☐	☐	Mental, nervous or emotional disorder (including depression or anxiety)
☐	☐	Bone or joint disorder (including arthritis or rheumatism)
☐	☐	Reproductive system disease or disorder or infertility
☐	☐	Skin disease or disorder (including acne)
☐	☐	Alcohol or drug dependency
☐	☐	Diabetes, IDDM/NIDDM
☐	☐	Colitis, or Crohn's, IBS or any other bowel disorder

Yes	No	
☐	☐	Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)
☐	☐	Chronic headaches or migraine headaches
☐	☐	Neurological disorder, seizures, multiple sclerosis or paralysis
☐	☐	Cancer, tumour or leukemia
☐	☐	Chest and heart conditions
☐	☐	High blood pressure, stroke, blood disorder or elevated cholesterol
☐	☐	Hernia
☐	☐	Attention deficit hyperactive disorder
☐	☐	Chronic fatigue or Fibromyalgia
☐	☐	Back, limb or neck strain/pain
☐	☐	Any physical impairments, deformities or illnesses not covered above

Member's full name (please print) ___________________________

2 Have any of the listed dependent(s) required or used medical equipment in the past 12 months or in the foreseeable future need medical equipment?

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial limbs, braces, walker or cane	☐	☐	Diabetic supplies or equipment	☐	☐	Orthopedic shoes, orthopedic supplies or arch supports
☐	☐	Hearing aid	☐	☐	Ostomy supplies	☐	☐	Ambulance services or nursing care
☐	☐	Wheelchair	☐	☐	Nebulizer	☐	☐	Non-traditional medicinal therapy (Naturopathic or Homeopathic)
☐	☐	Oxygen						

3 Have any of the listed dependent(s) consulted or received treatment from a medical professional in the past two years?

Yes	No		Yes	No		Yes	No	
☐	☐	Physician	☐	☐	Acupuncturist	☐	☐	Chiropodist/Podiatrist
☐	☐	Chiropractor	☐	☐	Massage Therapist	☐	☐	Psychologist
☐	☐	Physiotherapist						

4 Provide details for each **YES** answer given in Questions 1–3 as well as details on any additional physical impairments, disease or disorders that you or your dependents have that are not listed.

Person's name	Illness/condition or equipment specialist	First treatment date (mm/dd/yyyy)	Treatment duration	Treatment type	Treatment results/ extent of recovery	Treatment provider (name/address/phone)

5 Have any of the listed dependent(s) taken any prescription medication for any reason in the last six months or have a prescription for which refills are currently authorized (including oral medication, serum, injection, drops, creams and suppositories)? ☐ Yes ☐ No

If **YES**, provide details below:

Person's name	Prescription name	Strength	Quantity taken	Cost per month	Number of refills per year	Reason

6 Are any of the listed dependent(s) pregnant? ☐ Yes ☐ No

If **YES**, what is the person's name ___________________________ and due date (mm/dd/yyyy) _______________

Member's full name (please print) ____________________

7 Have any of the listed dependent(s) smoked or used tobacco in the last 12 months? ☐ Yes ☐ No

If **YES**, please provide details below:

Person's name	Type of tobacco use	How often (e.g., number of cigarettes per day)

8 During the past five years, have any of the listed dependent(s) used marijuana, cocaine, hallucinogenic or narcotics (e.g., morphine or heroin), sedatives or tranquilizers, except as prescribed by a physician? ☐ Yes ☐ No

If **YES**, indicate person's name(s), type and how often per day ____________________

9 **MEMBER DECLARATION (Complete only if NO medical conditions)**

If in the foregoing questions 1–8 you answered **NO** throughout and your dependents have no physical impairments, disease or disorders, please confirm by initialing in the box to the right.

Member's initials

PART 3 — MEMBER'S SIGNATURE

I certify that all information shown above is correct. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, or my dependents and their health, to give to Pacific Blue Cross such information. A photographic copy of this authorization shall be as valid as the original.

Member's name	X Member's signature	Date (mm/dd/yyyy)
Spouse's name (if applicable)	X Spouse's signature	Date (mm/dd/yyyy)

**Pacific Blue Cross is a registered trade-mark of the Canadian Association of Blue Cross Plans (CABCP) and registered trade-name of PBC Health Benefits Society (PBC), an independent licensee of CABCP. Life, Disability, Accidental Death & Dismemberment and Critical Illness insurance is underwritten by Blue Cross Life Insurance Company of Canada. †Blue Shield is a registered trade-mark of Blue Cross Blue Shield Association. All rights reserved.