PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

APPLICATION FOR INDIVIDUAL 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

- Print in ink or type information.
- Please review Part 4 Health Summary Questions to determine eligibility prior to completing the whole Application form.

BROKER/OFFICE USE ONLY			QUOTE NUMBER
Application number	ID number	Broker ID (for Broker/Agent use only)	(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: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000	Policy term ☐ 10 year term, renewable to age 75 ☐ 20 year term, renewable to age 75 ☐ Term to age 75

PART 3 — 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 4 — HEALTH SUMMARY QUESTIONS

This application is not valid unless the questionnaire is fully completed and signed. If you answer 'yes' to any of the following questions, you will not be eligible for coverage.

QUESTIONNAIRE	APPLICANT
1. In the past 5 years:	
a) Have you had an application for Critical Illness insurance declined, postponed or offered with a rating or exclusion?	☐ Yes ☐ No
b) Have you received any treatment, medical advice, been diagnosed with, required any follow up for or had any known indication of high blood pressure or high cholesterol?	☐ Yes ☐ No
c) Have you been admitted to a hospital or other medical facility for 48 hours or more?	☐ Yes ☐ No
d) Have you had any illness or injury which prevented you from performing your usual activities, occupational duties or attending school for more than 10 consecutive days?	☐ Yes ☐ No
e) Have you been treated or counseled for or, joined or been advised to join an organization or program due to alcohol or drug use?	☐ Yes ☐ No
f) Have you used marijuana (more than 3 times a week) or any narcotics, cocaine, heroin, morphine, fentanyl, demerol, LSD, hash, hallucinogens, amphetamines, barbiturates, tranquilizers, or anabolic steroids, or any drug not prescribed by a licensed physician?	☐ Yes ☐ No
2. Have you ever been told you have, received treatment or medical advice for, or had any known indication of:	
a) Coronary artery disease, angina, angioplasty, bypass surgery, valve disease, heart attack, stroke, transient ischemic attack (TIA) or any other cerebrovascular disease or disease of the heart or circulatory system?	☐ Yes ☐ No
b) an abnormal electrocardiogram (ECG), holter or echocardiogram?	☐ Yes ☐ No
c) Diabetes, abnormal blood sugar, abnormalities of the thyroid (excluding hypothyroidism controlled with medication), pituitary, lymph or adrenal glands, or endocrine disorder?	☐ Yes ☐ No
d) Cancer or other malignant disease, benign or malignant tumour, abnormal pap test, irregular shaped/coloured moles or lesions, biopsy-proven skin cancer, colon polyp or any other growth?	☐ Yes ☐ No
e) Breast disease or disorder, breast mass, breast cyst, physical changes in or abnormal discharge from the breast, abnormal mammogram or breast biopsy, or prostate problems, prostate nodule(s) or abnormal PSA or ultrasound results?	☐ Yes ☐ No
f) AIDS, HIV or AIDS-related illness, persistent enlarged lymph glands, chronically abnormal blood work or any immunological disorder such as Lupus?	☐ Yes ☐ No
g) Hepatitis B or C (including hepatitis B carrier state), abnormal liver function tests, biopsy or ultrasound results or any form of liver disease?	☐ Yes ☐ No
h) Crohn's, Ulcerative colitis, rectal bleeding, abnormal colonoscopy results, or any other disorder of the stomach, pancreas, colon, rectum, reproductive organs?	☐ Yes ☐ No
3. Do you have any medical conditions for which you are under observation or treatment including investigations, tests or surgery that have been advised but not yet carried out, or for which you are awaiting test results (excluding the common cold, regular physicals or blood work completed as part of the physical)?	☐ Yes ☐ No
a) Do you have any symptoms or complaints, including persistent or undiagnosed pain, shortness of breath or problems regarding your health for which you have not yet consulted a physician or received treatment?	☐ Yes ☐ No
4. Have 2 or more of your immediate family members (mother, father, brother or sister) been diagnosed with or treated for Heart Disease, Aneurysm, Stroke, Cancer, Diabetes, Polycystic Kidney Disease, prior to age 60?	☐ Yes ☐ No
5. Does your height and weight fall outside the chart below?	☐ Yes ☐ No

Height in inches	Max weight in lbs
56	174
57	180
58	186
59	193
60	199
61	206
62	213
63	220
64	227
65	234
66	241
67	249

Height in inches	Max weight in lbs
68	256
69	264
70	272
71	279
72	287
73	295
74	289
75	312
76	320
77	329
78	337

PART 5 — 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 6 — 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 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	

PART 8 — 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.