PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

INDIVIDUAL PLAN LATE APPLICANTS DENTAL DECLARATION

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

MEMBERS — Please complete RED portions of this application.
DENTISTS — Please complete BLACK portions of this application.
Please complete one form for each late applicant.

OFFICE USE ONLY

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

PART 1 — MEMBER INFORMATION

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

Policy number	ID number	Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F

PART 2 — DEPENDENT INFORMATION

First name	Last name	Middle initial	Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F

PART 3 — DENTIST: Complete this section after examining the person listed above

I have examined the person listed above in *Part 2 — Dependent Information* and confirm that:

☐ Their dental health is good — no preventative or restorative measures are required.

☐ I expect or recommend the following treatment:

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Dentist's stamp

Remarks:

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NOTE: The member will be responsible for the cost of examination and completion of this form.

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

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