QUÉBEC BLUE CROSS®

AMI

INSURANCE APPLICATION

Representative number
Contract number
☐ New enrolment ☐ Change

ELIGIBILITY CONDITIONS

To be eligible for insurance, the primary insured and the spouse, if applicable, must be:

- insured under the *Quebec Health Insurance and Hospital Insurance Acts*;
- 16 years of age or more.

In addition, they must not be hospitalized on the effective date of the contract.

1 – PERSONAL INFORMATION

Primary insured

Last name	First name		
Date of birth	Gender F/M	E-mail	Language of correspondence ☐ English ☐ French

Spouse

Last name	First name	Date of birth	Gender F/M

Dependent child

Last name	First name	Date of birth	Gender F/M

Dependent child

Last name	First name	Date of birth	Gender F/M

Dependent child

Last name	First name	Date of birth	Gender F/M

Address

No.	Street	Apt.
City	Province	Postal code

Telephone

Home	Work (optional)

2 – PLAN SELECTION

◆ Referring to the enclosed rate chart, indicate the premium amount (monthly or annual) in the appropriate box. Then indicate the grand total.

PLAN A **Hospitalization and Diagnostic services**

PLAN B **Hospitalization and Extended health care**

OPTION **Home health care benefit** (This optional benefit is available only when enroling in plan A or B)

Plan	Family coverage		Individual coverage
☐ Plan A ☐ Plan B	$	OR	$
☐ Optional benefit	$		$
Total	**$**		**$**

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MONTHLY PAYMENT INFORMATION

CREDIT CARD OR PRE-AUTHORIZED DEBIT (PAD)

First payment

The first payment is debited on the date of receipt of the application.

Subsequent payments

Once the application is accepted, subsequent payments will be debited every month:

Credit card: on the effective date of the contract.

Pre-authorized debit (PAD): indicate the day: __________ (must be between the 1st and 28th inclusively). If the chosen day is the 29th, 30th or 31st, the withdrawal date will be the 28th.

3 – METHOD OF PAYMENT

☐ **CREDIT CARD** (MONTHLY) ☐ Mastercard ☐ VISA ☐ American Express | Monthly premium $

Card no. | Expiration MM | YY

Name (please print) | Credit cardholder signature

☐ **CHEQUE** (ANNUAL) Please enclose a cheque payable to Québec Blue Cross.

☐ **AUTOMATIC BANK WITHDRAWAL** (MONTHLY)
Please complete the section below, including the following page.

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

A – Payor information

Account holder		Joint account holder	
Last name	First name	Last name	First name

Address

No.	Street	Apt.
City	Province	Postal code

Telephone		E-mail
Home	Cell	

B – Bank account information

Financial institution

Name

Address

No.	Street	
City	Province	Postal code

Bank account

Institution no.	Branch transit no.	Account no.

C – Pre-authorized debit (PAD)

1. I, the undersigned, hereby authorize Blue Cross Canassurance, hereinafter called the Insurer, to debit my bank account identified above monthly, on the day indicated in the "Monthly payment information" section or the following business day, for the sum in accordance with my instructions for the periodic or one-time payment of my insurance policy. If no day is selected, I understand that the day will be determined by the Insurer without notice being sent to me.
2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to provide me with 30 days' advance notice only for the renewal of my policy.
3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution. I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.
4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten business days prior to a PAD.
5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service Department at 1-800-363-3958. **I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD.**
6. I understand that I may revoke this authorization at any time subject to providing ten days' notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit **www.cdnpay.ca.**
7. I understand that the Insurer may cancel this Agreement upon thirty days' written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.
8. I have certain recourse rights if any debit does not comply with the Agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

Signature	
Account holder	Joint account holder (if applicable)
Name of the account holder (please print)	Name of the joint account holder (please print)
Date	Date

4 – SIGNING OF THE INSURANCE APPLICATION

Signature	
Primary insured	Spouse
Date	Date

INCOME TAX RECEIPT

Receipts are mailed by February 28 of the following year.
Please notify Québec Blue Cross of any change of address.

NOTICE REGARDING PERSONAL INFORMATION

Québec Blue Cross aims to protect your privacy to the greatest possible extent. All personal information received regarding you is kept in a file titled "insurance file." The information we hold is confidential; only employees of the Insurer may consult your file, and only as justified as part of their job. Unless you object, this information may also be used for personalized solicitations by mail or telephone. You may consult your file and correct information as needed by writing to the Insurer at:

Québec Blue Cross, 1981, McGill College Avenue, Suite 105, Montreal, Quebec H3A 0H6