BLUE CROSS®

ADVISOR'S GUIDE

Expertise in health and travel insurance

V.2.5

Contact Information

Claims

Claims, Life and Disability insurance

Telephone: 1-800-300-5002
Fax: 1-877-590-7504
Email in Ontario: claimslife.disability@ont.bluecross.ca
Email in Quebec: claimslife.disability@qc.bluecross.ca

Commissions and Contracting

Telephone: 514-286-2626 / 1-800-361-2538 (option 2, then option 2)
Email: commission.contracting@qc.bluecross.ca

Info-Partners

Contract Administration
Underwriting

Telephone: 514-286-2626 / 1-800-361-2538 (option 2, then option 1)
Email in Ontario: info.partners.health@ont.bluecross.ca
Email in Quebec: info.partners.health@qc.bluecross.ca

Mailing Address

Ontario

Ontario Blue Cross
P.O. Box 4433, Station A
Toronto, ON M5W 3Y7

Quebec

Quebec Blue Cross
550 Sherbrooke Street West
Suite B-9
Montreal, QC H3A 3S3

Table of Contents

UNDERWRITING 20

Overview of Blue Cross Products

1. Personal Health Insurance AMI

Medical insurance supplemental to the RAMQ plan, offered in Québec to individuals ages 16 and older.

Table 1.1 AMI

Health Benefits	Optional Benefits
• Hospitalization • Diagnostic services OR • Hospitalization • Extended health care	• Home health care

2. Blue Choice, Blue Choice Balance, Basic Blue Choice

Products providing health coverage in Ontario.

Table 2.1 Blue Choice

Health Benefits	Optional Benefits
• Extended health care • Travel insurance • Hospitalization	• Prescription drugs • Dental care

Table 2.2 Blue Choice Balance

Health Benefits	Optional Benefit
• Extended health care • Accidental death and loss of use • Dental care • Prescription drugs • Travel insurance	• Hospitalization

Table 2.3 Basic Blue Choice

Health Benefits	Optional Benefit
• Extended health care • Accidental death and dismemberment • Dental care • Prescription drugs • Travel insurance	• Hospitalization

3. Blue Vision

The insured person can benefit from a comprehensive insurance policy with the different types of coverage offered in this product. Blue Vision is the Ontario version of Blue Flex.

Table 3.1 Global Plan

Individual Benefits	Optional Benefits
• Disability due to accident • Disability due to illness	• Regular occupation – disability due to accident • Premium refund (65) – disability due to accident • Regular occupation – disability due to illness • Premium refund (65) – disability due to illness
• Monthly indemnity due to accident • Monthly indemnity due to illness	
• Overhead expenses	
• Term life 65	
Individual, Single-Parent, Couple and Family Benefits	**Optional Benefits**
• Hospital allowance	
• Extended health benefit	• Drug benefit • Dental care

Table 3.2 Express Plan

Individual Benefits	Optional Benefits
• Life express • Accidental death • Accidental loss of use	
• Hospital allowance express	• Premium refund upon death – hospital allowance express
• Critical illness assistance	• Premium refund at termination date – critical illness assistance
• Monthly indemnity due to accident express • Monthly indemnity due to illness express	
Individual, Single-Parent, Couple and Family Benefits	
• Accidental fracture • Post-accident adaptations • Medical expenses due to accident • Home health care	• Express plan health package • Dental care (Global plan) • Travel insurance
Benefits for all Insured Children	
• Life, accidental death and loss of use - child	

4. Blue Flex

The insured person can benefit from a comprehensive insurance policy with the different types of coverage offered in this product. Blue Flex is the Quebec version of Blue Vision.

Table 4.1 Flex Plan

Individual Benefits	Optional Benefits
• Disability due to accident • Disability due to illness	• Regular occupation – disability due to accident • Premium refund (65) – disability due to accident • Regular occupation – disability due to illness • Premium refund (65) – disability due to illness
• Monthly indemnity due to accident • Monthly indemnity due to illness	
• Overhead expenses	
• Term life 65	
Individual, Single-Parent, Couple and Family Benefits	**Optional Benefits**
• Hospital allowance	
• Extended health benefit	• Drug benefit • Dental care

Table 4.2 Express Plan

Individual Benefits	Optional Benefits
• Life express • Accidental death • Accidental loss of use	
• Hospital allowance express	• Premium refund upon death – hospital allowance express
• Critical illness assistance	• Premium refund at termination date – critical illness assistance
• Monthly indemnity due to accident express • Monthly indemnity due to illness express	
Individual, Single-Parent, Couple and Family Benefits	
• Accidental fracture • Post-accident adaptations • Medical expenses due to accident	• Home health care • Travel insurance (including cancellation and baggage)
Benefits for all Insured Children	
• Life, accidental death and loss of use - child	

5. Mortgage Plan

Available in Quebec and Ontario, this plan covers the mortgage loan individually for a borrower and co-borrower on the same policy.

Table 5.1 Mortgage Benefits

Benefits	
• Mortgage life	• Mortgage disability

6. Tangible

Available in Quebec and Ontario, this plan offers a progressive coverage with hybrid benefits that gradually transition into long-term care insurance coverage.

Table 6.1 Tangible Benefits

Critical Illness Benefits	Optional Benefits
• Critical illness (basic or deluxe)	• Premium refund (20) or (65) • Waiver of premiums in case of disability of the primary insured
• Critical illness multi-protection (per child)	• Premium refund (20) • Waiver of premiums in case of disability of the primary insured or the policyholder
Long-Term Care Benefits	**Optional Benefits**
• Facility care	• Cost-of-living increase • Premium refund upon death
• Home care (Facility care mandatory)	• Cost-of-living increase • Premium refund upon death
• Hospitalization and loss of autonomy	
Hybrid Coverage Benefits	**Optional Benefits**
• Life – Hybrid coverage • Home care – Hybrid coverage (Life)	• Waiver of premiums in case of disability of the primary insured or the policyholder • Cost-of-living increase (Facility care) • Cost-of-living increase (Home care)
• Critical illness – Hybrid coverage • Home care – Hybrid coverage (Critical illness)	• Waiver of premiums in case of disability of the primary insured or the policyholder • Cost-of-living increase (Facility care) • Cost-of-living increase (Home care)
• Loss of autonomy – Hybrid coverage • Home care – Hybrid coverage (Loss of autonomy)	• Waiver of premiums in case of disability of the primary insured • Cost-of-living increase (Facility care) • Cost-of-living increase (Home care)
• Disability – Hybrid coverage	• Regular occupation • Home care – Hybrid coverage (Disability) • Cost-of-living increase (Facility care) • Cost-of-living increase (Home care)

Commissions and Contracting

1. Role of the Commissions and Contracting Department

The Commissions and Contracting Department is responsible for managing Blue Cross partnership agreements, including creating partners' files, updating files, terminating contracts, handling commissions and account reconciliations.

To become a Blue Cross partner, to get more information, or to change your existing contract with Blue Cross, contact the Commissions and Contracting Department. Refer to the Contact Information section (p. I).

You will be asked a series of questions each time you call to confirm your identity and protect the confidentiality of our advisors' files.

2. Submitting a Contract

2.1 Required Documents

The following documents must be submitted by mail, email, or fax with Blue Cross applications for partnership:

- Copy of a valid licence
- Copy of liability insurance
- A voided cheque
- Completed and signed Representative's agreement
- Distributor sheet

2.2 Required Licences

To be able to sell Blue Cross products, you must have the licence required by your province and brokerage type.

In Ontario

- Brokerage firm:
  - Valid insurance agent licence issued by the Financial Services Commission of Ontario
- Independent advisor:
  - Valid insurance agent licence issued by the Financial Services Commission of Ontario

In Quebec

- Brokerage firm:
  - Valid "Insurance of persons" representative certificate issued by Autorité des marchés financiers
- Independent advisor:
  - Valid "Insurance of persons" representative certificate issued by Autorité des marchés financiers

Other Canadian provinces

- Independent advisor:
  - Valid insurance agent licence for the province in which the partner does business

Licences not accepted by Blue Cross

- Damage insurance licences are not accepted

2.3 Liability Insurance

This insurance grants advisors coverage against the consequences of their civil liability in case of error, fault, negligence, or omission committed in the pursuit of their professional activities.

Professional liability insurance is required because it protects both professionals and their clients.

3. Requirements to Sell Blue Cross Insurance

- Have and maintain a valid licence by adhering to the laws applicable in the province in which you intend to do business
- Have and maintain valid professional liability insurance
- Comply with the contract signed with Blue Cross at all times

To prevent payment delays and ensure you are able to log in to the Info-Partners site, please send us:

- Your renewed licence and liability insurance information before they expire
- Your updated information, as required

4. Partners' Commissions

4.1 Commission Reports

Commission reports are available on the Info-Partners website. Records are kept for one year.

You must have an administrative code to access the Commission Reports section.

4.2 Partner Commission Rates

Commission rates are set out in your contract with Blue Cross. Rates are based on the benefits sold, among other factors, and the percentage varies with the contract age.

4.3 Paying Commissions

Commissions due are paid via direct deposit to a designated bank account.

Amounts owing can be paid by cheque or credit card (payment information must be given over the telephone).

4.4 Commission Payment Frequency

Weekly: For advisors selling personal health products, with or without travel products

- The weekly commission statement period is Sunday to Saturday
- Commissions are paid the Monday after the end of the period, unless it is a holiday

Monthly: For advisors selling travel products only

- The monthly commission statement period is the first to the last day of the month
- Commissions are paid on the first business day of the following month

5. Updating a File

5.1 Updating Contact Information

To change an address, telephone number, or email address, email a request to Commissions and Contracting.

5.2 Changing Banking Information

To change bank accounts, email a request to Commissions and Contracting. Be sure to include:

- Bank account change form
- A copy of a voided cheque for the new account
- Your distributor number

6. Types of Insurance Sold by Our Partners

6.1 Personal Insurance (Health Products)

- Blue Vision (health, dental, disability, life insurance, etc.)
- Tangible (critical illness insurance, long-term care, hybrid benefits)
- Mortgage (mortgage life and disability insurance)

This type of insurance is sold by:

- Distributors in the brokerage network (under Managing General Agency [MGA])

  Distributors that would like to sell personal insurance products must do so through a MGA.

6.2 Travel Insurance (Travel Products)

- Individual travel insurance
- Summertime Blue
- Package
- Visitors to Canada
- Annual insurance, etc.

This type of insurance is sold by:

- Distributors in the brokerage network (under MGA)

7. T4-A & RL-1 Slips

Only independent advisors and companies registered (in Quebec) that have been paid commissions during the year in question will receive a T4-A and/or RL-1 slip.

There is no minimum threshold in Quebec, but in Ontario and the Atlantic provinces, it is $500.

The following types of partners are not given a T4-A or RL-1 slip:

- Corporations
- LLCs
- Partnerships
- For Quebec: businesses registered outside Quebec
- Advisors whose commissions are paid to a legal person that previously had a contract with Blue Cross

End-of-year statements are issued to:

- The bank account holder
- Commission cheque recipients

Receipts for the fiscal year in question are issued no later than February 28, as required by law.

8. Transferring a Portfolio

Contact Commissions and Contracting to find out how to transfer a portfolio.

9. Sponsoring New Advisors

To become licensed, advisors new to the industry must be sponsored by an insurer for two years.

Blue Cross participates in the new advisor sponsorship program for life insurance and accident/sickness insurance for Ontario and the Atlantic provinces.

9.1 Sponsorships in Ontario

9.1.1 Requirements

The sponsoring insurer (Blue Cross) must submit a sponsorship application to the Financial Services Commission of Ontario (FSCO).

To be sponsored by Blue Cross, the new advisor must provide the following to its MGA or Blue Cross:

- Full legal name
- Date of birth
- Mailing address
- Any bankruptcies declared within the past year
- Telephone number and email address
- For transfers, the advisor must also provide the end date for its current sponsorship.
- An official letter of recommendation from the MGA stating that the advisor is a potential sponsorship candidate.

Once all required information has been received, our Commissions and Contracting Department will submit the sponsorship application to FSCO.

As the sponsoring insurer, Blue Cross trusts that you will represent its products with pride.

9.1.2 Sponsorship Types

Blue Cross offers three types of sponsorships in Ontario:

- Sponsorship of a new agent
- Sponsorship transfer: an existing agent wishing to change sponsoring insurers
- Sponsorship of an advisor who left the industry but would like to go back to selling insurance

9.1.3 Processing Time

FSCO will email the advisor directly to confirm once the application has been processed.

9.1.4 Fees

Sponsorship applications incur a fee. FSCO will inform the advisor of these fees directly.

For more information, please contact:

Financial Services Commission of Ontario (FSCO)
Licensing and Market Conduct Division

5160 Yonge Street
4th Floor
Toronto, Ontario M2N 6L9

Telephone: 416-250-7250
Toll-free: 1-800-668-0128
Fax: 416-590-7070
Email: contactcentre@fsco.gov.on.ca

9.2 Sponsorships in the Atlantic Provinces

9.2.1 Requirements

In the Atlantic provinces, advisors are required to use a form to submit a sponsorship application. The application form must be duly completed by the advisor and finalized and signed by an authorized signatory of Blue Cross.

Once the two parties have completed the form, it must be sent to the province's relevant ministry for approval.

9.2.2 Sponsorship Types

Blue Cross offers two types of sponsorships:

- Sponsorship of a new agent
- Sponsorship renewal

9.2.3 Processing Time

The New Brunswick Insurance Branch will contact the advisor directly.

9.2.4 Fees

Sponsorship applications incur a fee. Please consult each government's website for posted fees or contact the agencies below for more information:

Newfoundland and Labrador
Government of Newfoundland and Labrador
Service NL
Financial Services Regulation Division
2nd Floor West Block, Confederation Building
P.O. Box 8700
St. John's, Newfoundland and Labrador A1C 4J6
Website: www.gs.gov.nl.ca

New Brunswick
225 King Street, Suite 200
Fredericton, New Brunswick E3B 1E1

Website:
http://www2.gnb.ca/content/gnb/fr/services/services_renderer.5655.Insurance_-_Life_Insurance_Agent_Licence_(Residents_and_Non-residents).html

Nova Scotia
General email address: fininst@gov.ns.ca
Forms available: www.gov.ns.ca/finance

Application and renewal forms and agency contract applications may be sent to the following addresses:

Nova Scotia Business Registry
P.O. Box 1529
Halifax, Nova Scotia B3J 2Y4

By regular mail:
Office of the Superintendent of Insurance
P.O. Box 2271
Halifax, Nova Scotia B3J 3Y8

By courier:
Office of the Superintendent of Insurance
1723 Hollis Street, 4th floor
Halifax, Nova Scotia B3J 1Y9

Prince Edward Island
Financial Market/Registrations
Prince Edward Island Securities Division
Registrations – Prince Edward Island Insurance Division
Registrations – Prince Edward Island Real Estate Division
Department of Justice and Public Safety
Website: www.gov.pe.ca/securities

Contract Administration

1. Role of the Contract Administration Department

The Contract Administration Department is responsible for entering received applications, issuing insurance policies, making changes, handling payments, cancelling policies as needed, and fielding our partners' questions via our Info-Partners service.

2. Submitting a New Application

In order to ensure that all of the relevant information is forwarded to the insurer, the insurance application includes a checklist.

It is important to attach the dated and signed individual insurance quotation or the summary of coverages to the application.

Quotes can be made using our software that calculates the insurance premium related to specific products. All the pertinent quotation tools can be found at www.info-partners.ca.

2.1 Applying for Express Plan and Global Plan Coverage

In Question 12.A – a), on page 21 of the insurance application, it is important to specify whether the policyholder would like Express plan coverage to be issued at the same time as Global Plan coverage. If this question is left unanswered, the Express plan will be issued while the Global will be sent to the Underwriting Department for analysis.

2.2 Signing Up for Mortgage Insurance

When submitting an application for mortgage insurance with a fixed term, the following information must be included:

- Mortgage amount
- Monthly mortgage payment
- Term
- Amortization period
- Underwriting, age, and amount requirements

Applications for mortgage insurance for a credit line (open loan) must also include:

- Total amount in the home equity line of credit
- Desired monthly payment
- All underwriting requirements, ages, and amounts

3. Documents Accepted Electronically

The following documents can be sent electronically (PDF) or by fax:

- Insurance application, including illustration or summary of coverage
- Health statement (by fax)
- Medical questionnaire (by fax)
- Pre-authorized debit (PAD) agreement
- Contract amendment
- Request for modification of the existing contract (change of address, banking information, contract cancellation, etc.)

Advisors must save the originals of any documents sent electronically for the life of the contract.

Exception: Medical information transfer authorizations
Authorization forms needed to obtain medical information from doctors, health professionals, hospitals, and clinics cannot be transmitted electronically. Because the aforementioned require the applicant's original signatures on authorizations less than ninety (90) days old, the insurer requests the document with the applicant's original signature.

4. Information Accepted Electronically

In order to modify or complete an application already submitted, the following information may be provided by telephone, fax or email (PDF):

- Date of birth (by fax)
- Height and weight
- Correction of first or last name
- Contact information of the insured
- Date of the pre-authorized debit or change to this date

You will find Contact information for the departments concerned at the beginning of this guide.

5. Premium Payment Methods and Frequencies

5.1 Pre-authorized Debit (PAD)

This payment method is available on a monthly basis.

The policyholder must

- Complete sections Method of payment and Pre-authorized debit (PAD) agreement of the application.
- Attach a void cheque.
- Ensure that the premium amount based on the chosen frequency **is available for debit upon receipt of the application.**

5.2 Credit Card

Payment by credit card is available on a monthly or annual basis.

The policyholder must

- Complete the Method of payment section of the application.
- Ensure that the premium amount established based on the chosen frequency **can be charged to credit card account upon receipt of the application.**

5.3 Cheque

Payment by cheque is only available on an annual basis.

The policyholder must

- Complete the Method of payment section of the application.
- Make a cheque payable to Blue Cross Canassurance and ensure **funds are available upon receipt of the application** for the annual premium amount.

6. Temporary Insurance Coverage

The temporary insurance coverage provided by the insurer allows the insured to be covered during the file analysis process. It is subject to certain conditions that vary depending on the product, as outlined in the insurance application.

You must sign and date page 13 of the insurance application and return it to the policyholder.

7. Application Tracking Report

A report entitled *Summary of application status for new business* is available on the Info-Partners website so advisors and their general representatives can track the progress of insurance applications submitted to Blue Cross. The report also shows change requests that include certain requirements.

Advisors can track where various files are in the process of being analyzed and issued. Once files come into force or are cancelled or declined, they no longer appear in the report.

Pay particular attention to the columns “Requirement pending – Underwriting” and “Approved – Administrative requirement pending” because they indicate the requirements for each file so that you will be able to contact the clients if need be.

The “pending since” column gradually changes colour, going from white to yellow to orange to indicate the urgency with which you must provide documents or information to keep the policy from being cancelled.

The report is updated every Monday but is available anytime.

8. Amending a Policy

Requests to amend a policy may be submitted whether the policy is in force or pending underwriting analysis, but certain requirements must be submitted in both cases. Also, any requests to increase or improve coverage will be analyzed by the Underwriting Department.

8.1 Effective Date of Amendments

The effective date of amendments requested by the policyholder varies depending on the coverage:

- **Quick issue insurance** (e.g., Blue Vision Express plan): the day after the policyholder signs the application
- **Coverage with underwriting**: the date the application is approved by the Underwriting Department

8.2 Authorized Amendments

Adding or modifying a Benefit

To add a benefit to the coverage in force or improve existing coverage, you must submit a new application:

- Check the Change box on page 1 and enter the contract number.
- Have the appropriate application declaration(s) signed and dated by the policyholder.
- Attach a copy of the dated and signed individual insurance quotation.
- Attach a Complete health statement or a telephone interview.

Adding or Removing a Child or Spouse

To add an individual to the coverage, you must submit a new application:

- Check the Change box on page 1 and enter the contract number.
- Complete section spouse/dependent children of the application.
- Have the appropriate application declaration(s) signed and dated by the policyholder and the spouse if applicable.
- Attach a copy of the dated and signed individual insurance quotation.
- Attach a Health statement, if applicable.

For the Blue Vision, Blue Choice Balance and Blue Flex products:

- in a single-parent or family plan, a child born after the date the contract enters into force is automatically covered as a dependent. A request signed by the policyholder must be sent to us for the change to be made to the contract.
- In a single or couple plan, a child born after the date the contract enters into force is automatically covered as a dependent, provided that the request be received within 30 days following the birth. After this delay, proof of insurability will be required.

For the Blue Choice product:

- a child born after the date the contract enters into force is automatically covered as a dependent, provided that the request be received within 30 days following the birth. After this delay, proof of insurability will be required.

Changing Payment Frequency

To change the premium payment frequency, you must send the insurer a request letter signed and dated by the payor.

Changing First or Last Name

To change the name of an insured, you must send the insurer a letter signed and dated by the policyholder with a change of name certificate issued by a government institution.

Changing Smoking Status

If the insurance policy was issued at the smoker rate and the insured has quit using tobacco products of any kind for over 12 months, he or she may ask to have it changed to the non-smoker rate.

To change the status from smoker to non-smoker, the policyholder must submit the following:

- A Short health statement with the “non-smoker rate” box checked, including medical authorization.
- A Tobacco use questionnaire.
- A urine HIV test if the insured amount is greater than $3,000 in disability insurance and $250,000 in life insurance.

Refer to the eligibility criteria in the Non-smoker Status section (page 21).

Leveling premiums

If a policy is initially issued with non-leveled, or “attained age” premiums, the policyholder has the option of requesting a change to level the premiums in the contract at the current age. This change does not require **any underwriting**.

Removing a Benefit

To remove a benefit from the coverage in force, the policyholder must submit a signed and dated letter that specifies the benefit to be removed.

Note that the benefit’s date of removal cannot be prior to the date of receipt of the request by the insurer.

Changing Employment

Since the occupational category of the policyholder is protected, it is not necessary to inform the insurer of a change of employment after the effective date of the contract, unless the new employment results in an enhancement of the category. In this case, the policyholder must ask for a change of occupation category.

For the modification to be made, a new application must be submitted:

- Check the change box on page 1 and provide the contract number.
- Have the appropriate application declaration(s) signed and dated by the insured.
- Submit a Short health statement*.
- Fill out an Occupation questionnaire.

*If the policy includes an exceeding amount, a Complete health statement will be required.

See the Occupational category reclassification section (page 34) or the Occupational categories document for more information.

Reconsidering an Exclusion or an Extra Premium

If an insurance policy was issued with an extra premium and/or an exclusion, they may be subject to reconsideration by Underwriting if one of the following circumstances applies:

- Underwriting indicated that a reconsideration of the initial decision may be possible.
- The insured believes that the medical or non-medical conditions leading to that decision have changed to an appreciable degree since the policy was issued and Underwriting’s initial decision could be reconsidered accordingly.

To obtain the reconsideration of an exclusion or extra premium, the policyholder must fulfill the following requirements:

- A modification request signed by the insured or the owner.
- A complete Health statement for the insured.
- Questionnaire on the specific condition of the insured if applicable.

The insurer reserves the right to request any other test or examination that may be required for the analysis.

9. Renewal

If the premium amount has changed, a renewal notice is sent to the policyholder **thirty-five (35) days prior to renewal**. This notice includes a contract summary and an invoice or a payment plan.

If premium amount has not changed, no document is sent.

Special Provision: Mortgage Plan

In the case of a Mortgage plan product, a renewal notice is sent ninety (90) days prior to the end of the term of the loan.

Monthly Report on Contracts to Be Renewed

A report indicating the contracts still in force but up for renewal the following month is available on the Info-Partners website.

10. Reinstatement

If a contract has lapsed following nonpayment of the premium, it can be reinstated at the insurer's discretion, according to the following guidelines.

Table 10.1 Guidelines

Time Elapsed Since Premium Due Date	Reinstatement Guidelines
30 days or less (grace period)	• Payment of the balance due
31* to 45 days	• Payment of the balance due
46** to 90 days	• Short health statement (including the policy number) • Payment of the balance due
More than 90 days	• Complete health statement (including the policy number) • Payment of the balance due

* As of the 31st day following non-payment of the premium, the insurer has the right to deny any claim submitted.

**On the 46th day following non-payment of the premium, the insurance file is forwarded to the Underwriting Department for analysis before proceeding with reinstatement.

Under the provisions of the contract, the insurer reserves the right to require proof with regard to the insured's medical condition.

Refer to section Cancellation by the Insurer for non-payment (page 18) for the standards of the insurer.

11. Changing the Effective Date/Backdating a Contract

11.1 Changing the Effective Date of a Contract

Any request to change the effective date of a contract must be addressed to the Underwriting Department and accompanied by the Declaration of good health. A policy may be postdated by no more than seven days.

If the Declaration of good health is submitted with the request, the new effective date will be the same as the date of signing of the declaration. If another date is specified, it must be before the date the Declaration of good health was signed.

If the Declaration of good health is not submitted with the request, the effective date will be the date on which the Underwriting Department accepted the application.

11.2 Backdating a Contract

A contract may be backdated to save age, however:

- Not if the purpose of the request is to make the client eligible for a benefit.
- The backdating cannot exceed three (3) months for most benefits.
- The backdating cannot exceed two (2) months for long-term care coverage.
- The backdating cannot exceed three (3) months for the Critical illness benefit and is only possible in exceptional circumstances. In such a case, an endorsement must be appended to the contract to specify that the date on which the moratorium clause for cancer takes effect is the issue date.

12. Reapplying for a Policy

In the event a contract has been cancelled, the insured has the option of submitting a new insurance application, subject to a new analysis by the Underwriting Department.

However, for Blue Choice contracts, the insured must wait at least 24 months after the contract is cancelled before submitting a new application.

13. Cancelling a Policy

13.1 Cancellation by the Policyholder

To cancel a contract, the policyholder must submit a signed and dated letter. The letter may be sent by regular mail, fax or email.

Should we receive such a request, we would then notify you by email, with the client's request in attachment, and grant you 10 days to clarify the situation with the client.

13.2 Cancellation by the Insurer for Non-payment

The Insurer grants a grace period of 30 days as of the due date, except in case of the first premium, which must be paid before the insurance comes into effect.

If the premium remains unpaid at the end of the grace period, the Insurer will mail a notice to the policyholder at the last known address indicating that the contract will be terminated retroactive to the due date unless the premium is paid within 15 days. If the delay elapses and the contract is cancelled, the policyholder will then have to request its reinstatement (page 16).

You will receive copies of any correspondence so you can follow up with your client to keep the policy from being cancelled.

13.3 Cancellation by the Insurer for Failure to Follow Up by the Insured

Following the communication sent by the insurer, a period of forty-five (45) days is granted to the insured so that the requested documents may be sent. At the end of this period, if the requirements have not been duly met, the contract is cancelled by the insurer for failure to follow up. The same period applies for an incomplete insurance application.

13.4 Cancellation upon Death of the Insured

In order to terminate the contract of an insured who is deceased, an attestation of death or a death certificate must be sent to the insurer.

For more information on life insurance claims, refer to section Claims - Life insurance (page 48).

14. Tax Receipt

No later than February 28 of each year, the insurer automatically sends accident/sickness insurance policyholders a tax receipt for the portion of the premium that qualifies for the medical fees tax deduction.

15. Documents Sent by the Insurer

The contract and entry-into-force requirements of the contract or coverage are sent to the MGA so that the advisor can deliver the contract with the following documents:

- Insurance policy
- Contract summary
- Insurance certificate (depending on coverage)
- Telephone interview
- Contract endorsement (where applicable)
- Exclusion clause (where applicable)

Table 15.1 Documents Sent by Blue Cross

		Recipients	CC
New Contracts	Quick Issue Insurance (e.g., Blue Vision Express Plan)	Policyholder • Summary • Contract	Advisor • Summary
	Underwritten Insurance	MGA OR Advisor (if without MGA)	MGA OR Advisor (if without MGA)
Requirements	Quick Issue Insurance (e.g., Blue Vision Express Plan)	MGA	n/a
	Underwritten Insurance	MGA	n/a
Cancellation	Quick Issue Insurance (e.g., Blue Vision Express Plan)	Policyholder	n/a
	Underwritten Insurance	MGA* OR Advisor (if without MGA)	n/a
Amendment	Quick Issue Insurance (e.g., Blue Vision Express Plan)	Policyholder • Summary • Contract	Advisor • Summary
	Underwritten Insurance	MGA OR Advisor (if without MGA)	n/a
Renewal	Quick Issue Insurance (e.g., Blue Vision Express Plan) And Underwritten Insurance	Policyholder If the premium changes • Renewal letter • Summary Payer • Bill or payment plan	Policyholder If policyholder is different • Bill or payment plan

* Unless cancelled by the insured, in which case, the documents will be sent to him/her.

Underwriting

1. Role of the Underwriter

The underwriter analyzes the information provided by a person to be insured to determine a premium based on age, job, current and past medical condition, and lifestyle. He or she may determine the scope of the coverage that the insurer may offer, the restrictive clauses, and any other contract condition.

The underwriter is responsible for limiting the insurer's exposure to excessive risk. To do this, he or she will accurately assess the risks posed by the insured's condition by taking into account a number of factors, including those listed below.

2. Eligibility Criteria

2.1 Disability Insurance

To qualify for disability insurance, the policyholder must meet the following minimum criteria:

- Be a permanent resident and have a valid social insurance number (SIN).
- Hold a valid provincial health care card.
- Not be hospitalized or disabled on the effective date of the contract.
- Work a minimum of twenty (20) hours per week eight (8) months per year.
- Apply for a minimum monthly benefit of $500.

2.1.1 Regular Occupation

- Client must have had the same job for at least two (2) years.
- The application must be approved at regular rates or with exclusions. An extra-premium would automatically result in the decline of this benefit.
- Stable work history within the same domain (ex.: an electrician may have several employers but always carry out the same electrical duties.)

2.1.2 Maternity leave

If the person to be insured is currently on maternity leave, she must wait until she is back at work full-time before subscribing a disability insurance.

2.2 Non-smoker Status

Non-smoker Status

The insured must not have used tobacco in any form (cigarettes, e-cigarettes, cigarillos, cigars, pipe, chewing tobacco or snuff, shisha, betel nut, or any other product derived from tobacco or containing nicotine) in the twelve (12) months preceding the insurance application or the review of status.

Occasional Cigar Smoker Status

Some cigar smokers may be considered as non-smokers provided that the following conditions are met:

- Smoke no more than twelve (12) cigars per year.
- Declare cigar smoking on the application or on the tobacco use questionnaire at the time of application.
- Test negative for cotinine (nicotine).

Note that the insured is not entitled to a second urine sample for a non-smoker status.

2.3 Instructions for Landed Immigrants

The risks associated with newcomers to Canada require special analysis and may occasionally entail additional requirements. For that purpose, the eligibility requirements of the insurer are as follows:

- Hold permanent Canadian resident status (landed immigrant).
- Have a valid SIN.
- Be proficient in English or French.
- Hold a valid provincial health care card.
- Work a minimum of twenty (20) hours per week eight (8) months per year.
- Have sources of income of Canadian origin.

Note that **refugees** and **holders of a student or work visa** do not qualify for an insurance contract.

Landed Immigrants in the Country for Less than a Year

The following documents are required by the insurer if a landed immigrant has been in the country for less than a year:

- Paramedical questionnaire or medical examination
- Blood profile with hepatitis B and C
- Foreign travel questionnaire

2.4 Body Mass Index

Body mass index (BMI) is a unit of measure calculated based on a person's height and weight. Health professionals use it to determine if a person is within a healthy weight range or at risk. For the most part, the higher the BMI, the greater the risk of developing health problems.

The information below is taken from Health Canada (www.sc-hc.gc.ca) and included in the guide for your reference only.

BMI is calculated using the formula BMI = weight (kg) / height $(m)^2$.

Note: To convert weight from pounds to kilograms → multiply the weight in pounds by 0.453592.
(1 lb = 0.453592 kg)

To convert height from inches to meters → multiply the height in inches by 0.0254.
(1 in. = 0.0254 m)

Table 2.4.2 Health Risk Classification According to BMI

BMI Category	Classification	Risk of Developing Health Problems
< 18.5	Underweight	Increased
18.5 – 24.9	Normal weight	Least
25.0 – 29.9	Overweight	Increased
30.0 and higher	Obese	High

Table 2.4.3 BMI Guide for Adults (18 and Up) According to Heath Canada

BMI		Height (m)																
		1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.64	1.66	1.68	1.70	1.72	1.74	1.76	1.78	1.80
18	Weight (kg)	40	41	42	43	44	46	47	48	49	50	52	53	54	55	57	58	59
19		42	43	44	45	47	48	49	50	51	52	54	55	57	58	59	61	62
20		44	45	47	48	49	50	52	53	54	55	57	58	60	61	62	64	65
21		46	47	49	50	51	53	54	55	57	58	60	61	62	64	65	67	68
22		48	50	51	53	54	55	57	58	60	61	62	64	65	67	68	70	72
23		50	52	54	55	56	58	59	61	62	64	65	67	68	70	72	73	75
24		53	54	56	57	59	60	62	63	65	66	68	70	71	73	75	76	78
25		55	57	58	60	61	63	64	66	68	69	71	73	74	76	78	80	81
26		57	59	60	62	64	65	67	69	70	72	74	75	77	79	81	83	85
27		59	61	63	64	66	68	69	71	73	75	77	78	80	82	84	86	88
28		61	63	65	67	69	70	72	74	76	78	79	81	83	85	87	89	91
29		64	66	67	69	71	73	75	76	78	80	82	84	86	88	90	92	94
30		66	68	70	72	73	75	77	79	81	83	85	87	89	91	93	95	98
31		68	70	72	74	76	78	80	82	84	86	88	90	92	94	96	99	101
32		70	72	74	76	78	80	82	84	86	89	91	93	95	97	99	102	104
33		72	74	77	79	81	83	85	87	89	91	93	96	98	100	103	105	107
34		75	77	79	81	83	85	87	90	92	94	96	99	101	103	106	108	110
35		77	79	81	83	86	88	90	92	95	97	99	102	104	106	109	111	114

3. Underwriting Requirements

3.1 Standards for Underwriting and Inspection Reports

- The age used is the age attained by the person to be insured on the date of signing the application.
- Indicated amounts correspond to the total amount of insurance in force in the past twelve (12) months including the insurance amount requested in the application.
- The Underwriting Department may require additional review, tests or examinations.
- For persons to be insured aged 0 to 15, the telephone interview must be completed with the policyholder.
- The paramedical questionnaire can be replaced with a telephone interview with vital signs.
- When overhead expenses are requested with the disability insurance, 50% of the amount of the overhead expenses must be added to the Disability due to Illness benefit to determine the requirements.
- For overhead expenses, the general business expenses questionnaire must be submitted.
- If the representative or advisor has not opted for the telephone interview, he or she must ask one of the authorized companies for all the medical requirements and the inspection reports.

Table 3.1.1 Underwriting Requirements for

- > Disability due to Illness (Blue Flex, Blue Vision)
- > Overhead Expenses (Blue Flex, Blue Vision)
- > Mortgage Disability (Mortgage Plan)

Age	Insured Amount					
	0 TO $1,000	$1,001 to $2,000	$2,001 to $2,500	$2,501 to $3,000	$3,001 to $4,500	More than $4,500
16 - 35	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile • Regular inspection report	• Paramedical • Urine HIV test • Blood profile • Regular inspection report
36 - 45	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile • Regular inspection report	• Paramedical • Urine HIV test • Blood profile • Regular inspection report
46 - 50	• Health statement OR • Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile • Regular inspection report	• Paramedical • Urine HIV test • Blood profile • Regular inspection report
51 and Over	• Telephone interview • Urine HIV test	• Telephone interview • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test	• Paramedical • Urine HIV test • Blood profile • Attending physician statement	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report • Attending physician statement	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report • Attending physician statement

Table 3.1.2 Underwriting Requirements for

> **Term Life 65 (Blue Flex, Blue Vision)**
> **Mortgage Life (Mortgage Plan)**

Age	Insured Amount					
	0 to $99,999	$100,000 to $200,000	$200,001 to $300,000	$300,001 to $500,000	$500,001 to $1,000,000	More than $1,000,000
0 - 17	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview	• Telephone interview • Vital signs • Attending physician statement
18 - 35	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview AND • Urine HIV test	• Health statement OR • Telephone interview AND • Urine HIV test	• Telephone interview • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile
36 - 40	• Health statement OR • Telephone interview	• Health statement OR • Telephone interview AND • Urine HIV test	• Telephone interview • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Paramedical • Urine HIV test • Blood profile
41 - 45	• Health statement OR • Telephone interview	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report
46 - 50	• Health statement OR • Telephone interview	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report
51 - 60	• Telephone interview • Vital signs	• Telephone interview • Vital signs • Urine HIV test	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • Urine HIV test • Blood profile	• Telephone interview • Vital signs • ECG • Blood profile • Urine HIV test	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report
61 and Over	• Telephone interview • Vital signs	• Telephone interview • Vital signs • Urine HIV test	• Paramedical • Urine HIV test • ECG • Blood profile	• Paramedical • Urine HIV test • ECG • Blood profile	• Paramedical • Urine HIV test • ECG • Blood profile	• Paramedical • Urine HIV test • Blood profile • ECG • Regular inspection report • Attending physician statement

Table 3.1.3 Underwriting Requirements for

- Critical Illness (Tangible)
- Multiple Protection (Tangible)
- Critical Illness – Hybrid Coverage (Tangible)
- Loss of Autonomy – Hybrid Coverage (Tangible)

Age	Amount Insured				
	Under $99,999	$100,000 to $250,000	$250,001 to $500,000	$500,001 to $1,000,000	$1,000,001 and More
30 days to 15 years	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile • Attending physician statement	• Telephone interview • Blood profile • Attending physician statement • Financial questionnaire	• n/a
16 - 40	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile • Attending physician statement	• Telephone interview • Blood profile • Attending physician statement • Financial questionnaire • Vital signs	• Medical examination • Blood profile • Attending physician statement • Financial questionnaire • ECG • Regular inspection report
41 - 50	• Telephone interview	• Telephone interview • Urine HIV test • Vital signs	• Telephone interview • Blood profile • Attending physician statement • Vital signs	• Telephone interview • Blood profile • Attending physician statement • Financial questionnaire • Vital signs • ECG	• Medical examination • Blood profile • Attending physician statement • Financial questionnaire • ECG • Regular inspection report
51 - 65	• Telephone interview • Blood profile (with PSA for men) • Vital signs	• Telephone Interview • Blood profile (with PSA for men) • Vital signs • Lifestyle questionnaire (for Hybrid coverage)	• Telephone interview • Blood profile (with PSA for men) • Attending physician statement • Vital signs • ECG • Lifestyle questionnaire (for Hybrid coverage)	• Telephone interview • Blood profile (with PSA for men) • Attending physician statement • Financial questionnaire • Vital signs • ECG • Lifestyle questionnaire (for Hybrid coverage)	• Medical examination • Blood profile (with PSA for men) • Attending physician statement • Exercise ECG • Chest radiograph • Vital signs • Lifestyle questionnaire (for Hybrid coverage)

Table 3.1.4 Underwriting Requirements for > Life – Hybrid Coverage (Tangible)

Age	Insured Amount					
	Under $50,000	$50,001 to $100,000	$100,001 to $250,000	$250,001 to $300,000	$300,001 to $500,000	$500,001 to $1,000,000
14 days to 17 years	• Telephone interview	• Telephone interview	• Telephone interview	• Telephone interview	• Telephone interview	• Telephone interview • Regular inspection report
18 - 40	• Telephone interview	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile • Regular inspection report	• Telephone interview • Blood profile • Vital signs • Regular inspection report	• Telephone interview • Blood profile • Vital signs • In-depth inspection report
41 - 50	• Telephone interview	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile • Vital signs • Regular inspection report	• Telephone interview • Blood profile • Vital signs • Regular inspection report	• Medical examination • Blood profile • ECG • Regular inspection report
51 - 65	• Telephone interview	• Telephone interview	• Telephone interview • Urine HIV test • Regular inspection report • Lifestyle questionnaire	• Medical examination • Blood profile • ECG • In-depth inspection report • Lifestyle questionnaire	• Medical examination • Blood profile • ECG • In-depth inspection report • Lifestyle questionnaire	• Medical examination • Blood profile • ECG • In-depth inspection report • Lifestyle questionnaire

Table 3.1.5 Underwriting Requirements for > Disability – Hybrid Coverage (Tangible)

Age	Insured Amount				
	Under $1,000	$1,001 to $2,000	$2,001 to $2,500	$2,501 $3,000	$3,001 and More
16 - 35	• Telephone interview	• Telephone interview	• Telephone interview	• Telephone interview • Blood profile	• Telephone interview • Blood profile • Regular inspection report
36 - 45	• Telephone interview	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile	• Telephone interview • Blood profile • Vital signs • Regular inspection report
46 - 50	• Telephone interview	• Telephone interview • Urine HIV test	• Telephone interview • Urine HIV test	• Telephone interview • Blood profile • Vital signs	• Telephone interview • Blood profile • Attending physician statement • Vital signs • Regular inspection report
51 - 55	• Telephone interview • Urine HIV test	• Telephone interview • Urine HIV test • Lifestyle questionnaire	• Telephone interview • Vital signs • Urine HIV test • Lifestyle questionnaire	• Telephone interview • Blood profile • Vital signs • Lifestyle questionnaire	• Telephone interview • Blood profile • Attending physician statement • Vital signs • ECG • Regular inspection report • Lifestyle questionnaire

In-depth inspection report: For monthly benefits of $4,500 and more.

Table 3.1.6 Underwriting Requirements for
> **Facility Care (Tangible)**
> **Home Health Care (Tangible)**

Age	Amount Insured	
	0 to $4,999	$5,000 to $10,000
16 - 50	• Telephone interview • Lifestyle questionnaire	• Telephone interview • Lifestyle questionnaire • Attending physician statement
51 - 65	• Telephone interview • Lifestyle questionnaire • Attending physician statement	• Telephone interview • Lifestyle questionnaire • Attending physician statement
66 - 70	• Telephone interview • Lifestyle questionnaire • Attending physician statement	• Telephone interview • Lifestyle questionnaire • Attending physician statement
71 and Over	• Telephone interview • In-person interview • Attending physician statement	• Telephone interview • In-person interview • Attending physician statement

Table 3.1.7 Underwriting Requirements for
> **Hospitalization and Loss of Autonomy (Tangible)**

Age	Insured Amount
	$25,000 and More
55 - 65	• Telephone interview • Lifestyle questionnaire • Attending physician statement
66 - 70	• Telephone interview • Lifestyle questionnaire • Attending physician statement
71 - 80	• Telephone interview • In-person interview • Attending physician statement

4. Document Validity

The following table specifies the validity period of the documents required for files to be analysed by the Underwriting Department. Beyond these periods, the documents cannot be considered by the insurer and new ones must be submitted by the insured.

Table 4.1 Validity Period

Documents	Validity Period
Health statement	90 days*
Paramedical questionnaire: • Health statement (page 3 of the questionnaire) • Vital signs (page 4 of the questionnaire)	90 days* 1 year
Medical examination: • Health statement (page 3 of the questionnaire) • Vital signs (page 4 of the questionnaire)	90 days* 1 year
Telephone interview	90 days*
Vital signs only	1 year
Blood profile and urine analysis	1 year
ECG	1 year
Application	6 months
Authorization (included in the application)	90 days

* A signed Declaration of good health is required after 90 days.

5. Financial Underwriting

5.1 Bankruptcy Standards

General Rules

Applicants who declared bankruptcy but have not been discharged or for whom a consumer proposal was presented do not qualify for disability insurance or the monthly indemnity. The application will be postponed until the applicant has been discharged.

The monthly indemnity of the Express plan may be offered if the insured meets the eligibility criteria set out in the application.

Maximum amounts of $100,000 in life insurance and $50,000 in critical illness insurance (any personal insurance coverage excluding group insurance) may be considered provided that bankruptcy was declared more than six (6) months ago.

General Rule for Discharge from Bankruptcy

> 1st bankruptcy

- Nine (9) months after the date bankruptcy was declared, unless a notice of objection to the discharge has been served.

> 2nd bankruptcy or more

- Twenty-four (24) months after the date bankruptcy was last declared, unless a notice of objection to the discharge has been served.

Specific Conditions for Occupational Categories 3A and 4A

A maximum amount of $3,000 in disability insurance may be considered provided that the following conditions are met:

- Minimum pre-tax income of $60,000
- No evidence of history of fraud
- No present or past nervous disorder
- No criticism of lifestyle
- Only one (1) bankruptcy, which must have been declared more than six (6) months ago

The benefit period is a maximum of five (5) years and the minimum waiting period is ninety (90) days.

5.2 Option: Submitting Proof of Income with the Application

General Rule

For all disability insurance products, except monthly indemnity and monthly indemnity Express, the insurer allows the policyholder to provide proof of income with the application. This option waives the requirement to submit evidence at the time of a claim.

Eligibility Requirements

The person to be insured must

- Request this option and provide proof of income with the application, as indicated in table Required documents (page 31).
- Have been in the same line of business for at least two (2) years if self-employed or a business owner.

A request to revisit a decision to decline the option due to ineligibility at the time of application can be made within two years following the effective date of the contract.

However, for it to be revisited, the option request must have been made during the initial application and accompanied by the applicable proof of income.

The minimum monthly benefits that can be subject to the option is $1,000 and the benefit period must be five years or up to age 65.

The person to be insured can also request the option if he or she is applying for an Association Program (page 38) or an SME Plan (page 39).

Table 5.2.1 General Rules

Monthly Benefit	$3,499 or Less	$3,500 or More
Salaried Employee	No evidence unless the insured chooses to provide proof of income with the application.	Proof of income required
Self-employed Worker or Registered Business	No evidence unless the insured chooses to provide proof of income with the application OR qualifies for the income enhancement.	Proof of income required
Incorporated Business Owner	No evidence unless the insured chooses to provide proof of income with the application OR qualifies for the income enhancement.	Proof of income required

Table 5.2.2 Required Documents

	Categories: A, 2A, 3A and 4A	Category: B
Salaried Employee	• T4 for the last completed year. OR • T1 General (Income tax and benefit return) – copy of pages 1 to 4 for the last completed year.	• Only the first $2,500 of disability insurance requested at the time of application qualify for financial underwriting. • Proof of income is required for the previous two (2) years.
Self-employed Worker or Business Owner	• T1 General (Income tax and benefit return) – copy of pages 1 to 4 for the last completed year. AND • Form T2125 – (Statement of business or professional activities) for the last two (2) completed years. The eligible income—indicated on line 9946—will be adjusted based on the income not eligible under the contract. OR • A complete copy of the financial statements for the last two (2) completed years, including the accompanying notes. The eligible income will be adjusted based on the income not eligible under the contract.	
Incorporated Business Owner	• A complete copy of the financial statements for the last two (2) last completed years, including the accompanying notes. The eligible income will be adjusted based on the income not eligible under the contract. AND • T1 General (Income tax and benefit return) – copy of pages 1 to 4 for the last completed year.	

Non-eligible Income

The following non-eligible income is also outlined in the insurance contract:

- Interest and investments
- Rentals
- Copyright
- Royalties
- Any income received from pension plans, annuity contracts, profit sharing plans, and deferred compensation plans
- Any other income not received directly in return for a service provided

List of Eligible Documents

- T1 General or T-1 General condensed: Income tax and benefit return
- T2 General: Corporation income tax return
- T2125: Statement of business or professional activities
- T2042: Statement of farming activities
- Company's financial statements
- T4: Statement of remuneration paid
- T5: Statement of investment income and/or Appendix 4 (must include information on the dividend source)
- Provincial notice of assessment (Quebec) (for monthly amounts of $3,000 or less) or Federal comparative summary (for monthly amounts of $3,000 or less)

Group Disability Insurance

If the client has group disability insurance, we require the following information:

- The percentage of income in the event of disability or the precise benefit amount.
- Whether or not the benefit is taxable.

5.3 Income Enhancement

Calculation Rules

The income enhancement is applicable to self-employed workers and business owners included in occupational categories B, A, 2A, 3A, and 4A.

A 20% enhancement in the net income earned is allowed up to a maximum of $40,000 at the time the amount available for monthly benefits is determined. The income after the enhancement must never exceed the gross income.

The enhancement will be calculated based on the eligible net income after expenses and before taxes, and on the lowest income of the two (2) previous years, for occupational categories B, A and 2A.

For categories 3A and 4A, we take the average of the past two years.

The income enhancement will also be considered in determining

- The income earned by self-employed workers and business owners that may entitle them to an occupational category reclassification.
- The amount of insurance, eligible for the option of providing proof of income at the time of application.

Eligibility Criteria

The person to be insured must:

- Be a self-employed worker or business owner in the same line of business for at least two (2) years.
- Provide personal tax returns and complete financial statements of the company for the last two (2) completed years, as indicated in section Required documents (page 31).
- Meet the following minimal conditions, based on the applicable status:

  - Registered business

    The registered business of the person to be insured must not have incurred any losses in the last two (2) completed years.

  - Incorporated business (Corporation)

    The incorporated business of the person to be insured must not have incurred any losses in the two (2) last completed years, be held by four (4) shareholders or fewer and at a minimum of 20% of the shares by the person to be insured. If the business is a corporation, the insurer takes into account the net income before taxes based on the percentage of shares held in the company and declared for the purposes of income tax, as well as the employment income on Line 101 (federal tax).

    The enhancement is applicable on the net income before tax of the company in the financial statements for the last two (2) completed years.

  - Self-employed or Sole owner of a registered business

    For a self-employed worker or sole owner of a non-incorporated company, the income earned is the gross income from which the insurer subtracts business expenses as submitted in the tax return, before personal taxes.

5.4 Income Splitting

For tax purposes, income may be split between the person to be insured and his or her spouse. In this case, the spouse's portion of income may be taken into account in the calculation of eligible income, but the spouse may not take out insurance coverage on the split income.

Information to be sent to the Insurer

Applicants who want to split income must make a written request to the insurer, providing the following information:

- Total amount of the income
- Amount after splitting the income between the two spouses
- Role of each spouse in the company
- Detailed description of the duties of the spouse
- Copy of the financial statements of the applicant and the T4s of the spouse

5.5 Treatment of Dividends

Dividends are not usually taken into account for disability insurance. These amounts represent the result of past work and are not constant with regard to the amount or the payment (e.g., dividends received following an investment in shares).

Dividend may be considered as income provided that the insured meets all of the following criteria:

- Be a self-employed worker
- Be in business for at least one (1) year
- Fully participate in his or her company
- Have a profitable business

Note that the dividends considered in determining the annual eligible income for the current year cannot exceed the company's net income before taxes.

6. Occupational Categories and Underwriting

6.1 Occupational Categories

In the Occupations tab of the quotation tool, the Occupational categories document outlines all the eligible occupations.

6.2 Occupational Category Reclassification

Eligibility Requirements

To qualify for any occupational category reclassification, the insured must

- Work outside the home more than half the time
- Have at least three (3) years of experience in the same profession or five (5) years of related experience
- Exceed the following income requirements for the last two years:

  - $35,000 for a reclassification from B to A, A to 2A, or 2A to 3A
  - $60,000 for a reclassification from 3A to 4A
  - $115,000 for a reclassification from A to 3A or from 2A to 4A

In the case of self-employed workers and business owners, the income enhancement will be taken into consideration in determining the income earned that may entitle the insured to occupational category reclassification.

Table 6.2.1 Occupational Category Reclassification

Categories*	Outside the Home > %50	3 Years in the Same Profession	OR	5 Years of Related Experience**	Income > $35,000 x 2 Years	Income > $60,000 x 2 Years	Income > $115,000 x 2 Years
B ➡ A	✓	✓		✓	✓		
A ➡ 2A	✓	✓		✓	✓		
A ➡ 3A	✓	✓		✓			✓
2A ➡ 3A	✓	✓		✓	✓		
2A ➡ 4A	✓	✓		✓			✓
3A ➡ 4A	✓	✓		✓		✓	

* Some occupations are subject to restriction and cannot be reclassified. Refer to the “Not eligible for reclassification” column in the Occupational categories document.

** Related experience: any experience related to the insured’s field of expertise or skill area, with a history of job stability.

A request for occupational category reclassification may be submitted up to five (5) years after the date of issue of a contract, under certain conditions.

If the request is made less than six (6) months after issuance of the contract, the insured must send the following to the insurer:

- Short health statement
- Proof of income
- Occupational questionnaire

If the request is made more than six (6) months after issuance of the contract, the insured must send the following to the insurer:

- Health statement or complete a telephone interview
- Proof of income
- Occupational questionnaire

6.3 Standards for Self-employed Workers and Salaried Employees Working from Home

In all cases, proof of earned income is required for:

1) An insurance amount of $3,500 or more
2) The option to submit proof of income with the application, unless otherwise stipulated below

Table 6.3.1 Standards

> **Disability Insurance – Blue Vision (Global Plan), Blue Flex (Flex Plan) and Tangible**

Occupational Category: 4A	Waiting Period	Benefit Period
Salaried employee and self-employed person working 0% to 100% from home		
- No proof of earned income	Chosen by insured	Chosen by insured
Occupational Category: 3A	**Waiting Period**	**Benefit Period**
Salaried employee working 0% to 100% from home		
- No proof of earned income	Chosen by insured	Chosen by insured
Self-employed person working 20% to 100% from home with a pre-tax income of at least $50,000 (Separate access – visible sign – foot traffic observed)*		
1) Same job or profession for the previous two years: - No proof of earned income **2) Different profession from previous job (less than two years):** - Must have been working from home for at least one year - Proof of earned income for the previous two years - Not available: option to submit proof of income with application **3) Different profession from previous job (less than one year working from home):** - Must have been working from home for at least 6 months - Maximum benefit of $1,300 - Not available: option to submit proof of income with application	Chosen by insured	Chosen by insured
Self-employed person working 20% to 100% from home with a pre-tax income lower than $50,000 (Separate access – visible sign – foot traffic observed)*		
1) Same job or profession for the previous two years: - Contracts or agreements for the upcoming year - Proof of earned income for the previous year **2) Different profession from previous job (less than two years):** - Must have been working from home for at least one year - Proof of earned income for the previous two years - Not available: option to submit proof of income with application **3) Different profession from previous job (less than one year working from home):** - Must have been working from home for at least 6 months - Maximum benefit of $1,300 - Not available: option to submit proof of income with application	Chosen by insured	Chosen by insured
Self-employed person working 20% or less from home		
- No proof of earned income - No minimum revenue	Chosen by insured	Chosen by insured

* If required by occupation

Occupational Categories: 2A, A, B	Waiting Period	Benefit Period
Self-employed person working 20% to 100% from home with a pre-tax income of at least $25,000		
(Separate access – visible sign – foot traffic observed)*		
- No proof of earned income	90 days	2 years 5 years
- Proof of earned income for the previous two years	Chosen by insured	Chosen by insured
Self-employed person working 20% to 100% from home with a pre-tax income of $17,000 to $25,000		
(Separate access – visible sign – foot traffic observed)*		
- Benefits according to earned income - Proof of earned income for the previous two years	90 days	2 years 5 years
Self-employed person working 20% or less from home		
- No proof of earned income - No minimum revenue	Chosen by insured	Chosen by insured

* If required by occupation

SPECIAL CASE	Waiting Period	Benefit Period
Educators with certification working 100% from home**		
- Benefits according to earned income - Proof of earned income for the previous two years - Visible sign - Foot traffic observed	90 days	2 years 5 years
Educators without certification working 100% from home**		
- Benefits according to earned income - Proof of earned income for the previous two years - Occupational Category: A - Minimum income of $12,000	120 days	2 years

**Certification: Licensed daycare or childhood education diploma

7. Overhead Expenses

Overhead expenses benefit covers business expenses during a disability period.

Table 7.1 Coverage Features

Categories	Maximum Monthly Benefit
B, A, 2A, 3A, 4A	$6,000
OO	Not eligible
Farmers	Not eligible
Waiting Period	
30 days (accident and illness)	30M days (30 days, except in the event of an accident or hospitalization of longer than 18 hours, where the benefit is payable on day 1)
Duration of Benefits	
2 years	

Table 7.2 Expense Eligibility

Eligible Expenses	Non-eligible Expenses
• Heating • Telephone • Electricity • Rent • Depreciation of equipment • Employee wages (firms with five [5] employees or fewer) • Business taxes • Accounting services • Other usual fixed costs necessary to run an office	• Merchandise costs • Accessories costs • Professional books costs • Equipment or supplies • Insured's salary and colleague's salary who replaces the insured

8. Associations

Association Program is the result of an agreement between the insurer, a partner and an association. It offers members of an official organization other than a business a set amount of coverage without a Complete health statement. A minimum number of insureds is set out in the agreement and it must be reached no later than the date indicated in said agreement.

Underwriting Standards

The general enrolment requirements for each member are as follows:

- A person to be insured may only apply once, using the Association form to take advantage of the associated privileges.
- The amount of time spent working for the association is not an eligibility criterion.

  For instance, if the person to be insured is a member of the Massage therapist association, but only spends 20% of their time doing that and works as a beautician 80% of the time, they can still apply for insurance.

Exceeding Amount

The exceeding amount is the amount requested above and beyond the amount provided under the Association plan. While the Association plan amount is issued upon receipt of the application, the exceeding portion must be studied by Underwriting.

However, Underwriting's analysis is based on the total insured amount (Association plan + exceeding amount) and the requirements (page 22) are set accordingly.

The exceeding amount may be approved as standard or with an extra premium and/or exclusion, or it may be rejected.

Table 8.1 Underwriting Acceptation Scenarios

Standard	Accepted with exclusion	Accepted with an extra-premium
Confirmation notice: The (12/12) exclusion for pre-existing conditions does not apply.	**Contract endorsement**: The (12/12) exclusion for pre-existing conditions does not apply. An exclusion applies to the exceeding amount for the duration of the contract, unless a reconsideration date has been set. AND For the first 12 months, this exclusion also applies to the amount granted under the Association Program.*	**Contract endorsement**: An extra-premium applies to the exceeding amount. The (12/12) exclusion for pre-existing conditions applies.(not specified in the endorsement).

***Example**

Insurance request:

- Amount granted under the Association Program: $1,500
- Exceeding amount: $500

After underwriting analysis, the entire insurance request is accepted with an exclusion for the right knee.

The contract endorsement sent with the contract will state that:

- The (12/12) exclusion for pre-existing conditions does not apply.
- The exclusion will apply to $2,000 (whole insured amount) for (1) year.
- As of the second year of coverage, the exclusion will apply only to $500 (exceeding amount).

When there is a claim, the pre-existing conditions will be verified for the Association Program amount, and incontestability verification will be done for the exceeding amount.

Option: Submitting Proof of Income with the Application

If the person to be insured would like the option to submit his or her proof of income with the application, they must submit the proof set out in the Required documents table (page 31).

9. SME Plan

The SME insurance plan is designed for small or medium enterprises. It offers members of a business a set amount of coverage without a Complete health statement, i.e., with the SME form declaration only. The SME plan must be approved by Blue Cross beforehand.

New employees of the SME have 120 days from their date of hire to sign up under the existing insurance policy.

Exceeding Amount

The exceeding amount is the amount requested above and beyond the amount provided under the SME plan. While the SME plan amount is issued upon receipt of the application, the exceeding portion must be studied by Underwriting.

However, Underwriting's analysis is based on the total insured amount (SME plan + exceeding amount) and the requirements (page 22) are set accordingly.

The exceeding amount may be approved as standard or with an extra premium and/or exclusion, or it may be declined.

Table 9.1 Underwriting Acceptation Scenarios

Standard	Accepted with exclusion	Accepted with an extra-premium
Confirmation notice: The (12/12) exclusion for pre-existing conditions does not apply.	**Contract endorsement**: The (12/12) exclusion for pre-existing conditions does not apply. An exclusion applies to the exceeding amount for the duration of the contract, unless a reconsideration date has been set. AND For the first 12 months, this exclusion also applies to the amount granted under the SME Plan.*	**Contract endorsement**: An extra-premium applies to the exceeding amount. The (12/12) exclusion for pre-existing conditions applies.(not specified in the endorsement).

***Example**

Insurance request:

- Amount granted under the Association Program: $1,500
- Exceeding amount: $500

After underwriting analysis, the entire insurance request is accepted with an exclusion for the right knee.

The contract endorsement sent with the contract will state that:

- The (12/12) exclusion for pre-existing conditions does not apply.
- The exclusion will apply to $2,000 (whole insured amount) for (1) year.
- As of the second year of coverage, the exclusion will apply only to $500 (exceeding amount).

When there is a claim, the pre-existing conditions will be verified for the SME Plan amount, and incontestability verification will be done for the exceeding amount.

Option: Submitting Proof of Income with the Application

If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the Required documents table (page 31).

10. MIB Group, Inc. (The Medical Information Bureau, Inc.)

10.1 Brief Description

- MIB Group, Inc. ("MIB") is a not-for-profit membership corporation whose members are life and disability insurance companies in the United States and Canada.
- MIB Group, Inc. is the largest and most effective organization aimed at detecting and reducing insurance fraud in North America.
- Its mission is to keep insurance premiums affordable for all consumers by helping the industry reduce fraud and adverse selection.

10.2 A Simple Process

MIB implemented a standardized process to transmit data:

- It collects medical and nonmedical information on insureds from its members in a coded format.
- It ensures the security of coded information.
- With authorization, it sends the codes to its members, without compromising the security or confidentiality of insureds' personal information.

10.3 Obtaining Information in the MIB File

MIB has put in place a simplified process for consumers to access information in their file. MIB can be reached at 1-866-692-6901 or through its website: www.mib.com

10.4 Contesting Reported Information

Insured persons have the right to contest the accuracy of information or the fact that their file is incomplete by sending a written request to the following address:

Director, MIB Disclosure Office
330 University Ave., Suite 501
Toronto ON M5G 1R7

11. Authorized Paramedical Organizations

The insurer has agreements with Canada's leading paramedical organizations, which allows great flexibility based on the insured's location.

Table 11.1.1 Organizations and Services

	Telephone Interview	Medical Reports	Inspection Reports	Paramedical	Blood Profile	Urine HIV Test	Laboratory Analyses	Resting and Exercising ECG
Dynacare	✓	✓	✓	✓	✓	✓		✓
ExamOne				✓	✓	✓	✓	✓

Claims – Disability Insurance

1. Role of the Analyst

The analyst receives disability insurance benefit claims from the insured, carries out the necessary follow-up and verification, and settles the claims.

The analyst also processes settlement claims that are eligible under fracture, long-term care, critical illness and accidental death and dismemberment coverage.

2. Initial Claim for Benefits

2.1 Submitting a Claim

Notice and Form

It is important to notify the insurer as soon as possible in order to begin the claim process, either by telephone or email. Refer to the Contact information (p. I) section.

Upon receipt of the notice, the insurer will send the Claimant's guide – Disability insurance containing all of the forms needed to analyze the insured's claim. The guide may also be downloaded from the insurer's website.

Upon receipt of the forms duly completed, a claim file will be created and will remain open during the entire disability period.

Period to submit a claim

Proof of disability must be submitted to the insurer within ninety (90) days of the onset of disability. The insured may be penalized or his or her claim may be denied if proof is provided after this period.

If the insured's physician delays in completing the Attending physician's statement, it is still best to send the forms that must be completed by the insured and the required documents with a note indicating that the physician's statement will follow later.

2.2 Required Documents

The following forms must be sent to the insurer within the ninety (90) days of the onset of the disability:

- Claimant's statement
- Authorization forms (6)
- Attending physician's statement
- Employer's or self-employed worker's statement
- Proof of Income, if required
- Request for payment by direct deposit (optional)

Claimant's Statement

This four (4) page form includes three (3) types of questions:

- Insured's personal and medical condition

  If the claim is the result of an accident, it is important to provide information on the circumstances of the accident.

- Insured's training and occupational experience

  Answers making it possible to redirect the insured on the professional market when he or she cannot resume his or her former duties.

- Insured's daily activities

  Answers making it possible to better understand the impact of the disability on the insured's self-care skills.

Authorization

Six (6) copies of the authorization forms must be signed and dated by the insured proving that he or she accepts the disclosure of personal and medical information so that the insurer can start processing the claim. If the authorizations do not accompany the initial claim, it will be deemed incomplete.

Attending Physician's Statement

This is a standard form that must be completed and signed by the attending physician and must be accompanied by a copy of the patient's medical record.

Note that the physician's fees to complete the form must be paid by the insured.

Employer's Statement

This two-sided form must be completed by the employer if the insured is a salaried employee. If a job description is available, the employer must attach a copy to the form.

Insured persons with more than one employer must have this form completed by each employer.

Self-Employed Worker's Statement

This form must be completed by the insured if he or she is a self-employed worker or the sole shareholder of his or her company.

Proof of Income

A disability benefit or monthly indemnity benefit aims to replace the insured's loss of income in the event of a disability. Income tax returns are therefore required to determine the pre-disability income.

Proof of income does not need to be submitted at the time of the initial claim provided that

- Proof of income was submitted and accepted when the policy was issued (the insured must, if applicable, justify increases in the amount insured subsequent to issuance of the contract).
- The amount insured is $1,200 per month or less for the first thirty-six (36) months.
- The insured is a member of an association and it has been agreed that the payable benefit is to be determined based on the number of beneficiaries under his or her care. The insured must produce official government documentation supporting this.
- The claim for benefits is related to a mortgage. A copy of the most recent statements indicating the payments made and the balance of the mortgage loan or line of credit must be attached to the claim.
- The claim is for a waiver of premium.
- The claim is for the Overhead expenses benefit.

In all other cases, the insurer reserves the right to require proof of income based on the status of the insured.

Salaried Employee

- Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability.
- Notices of assessment received from the federal and provincial governments.

Self-employed Worker

- Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability.
- Notices of assessment received from the federal and provincial governments.
- Copy of Form T2125 (Statement of business or professional activities), which was attached to the federal income tax return.

Shareholder

- Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability.
- Notices of assessment received from the federal and provincial governments.
- The company's financial statements.
- Schedule 50 from the company's federal income tax return for the last fiscal year.

2.3 Initial Decision

Upon receipt of the claim for benefits, the insurer will send a notice of receipt to the insured.

Once the claim has been analyzed by the Claims Department, the insured will be informed in writing of the initial decision, i.e., acceptance, denial, or further investigation. If any other documents are needed to process the claim, the insured will be notified.

Note that a copy of any correspondence is forwarded to the advisor.

3. Tasks Performed by the Analyst

Telephone Contact

During the process, the analyst will contact the insured to explain the status of the file, as needed, and collect any missing required information.

There will be regular telephone communication between the analyst and the insured. Note that telephone conversations may be recorded for training and quality control purposes.

Medical Record Request

In some cases, the analyst will request a complete copy of an insured's medical record. This information is needed for the insurer to properly determine the validity of a claim.

In-person Interview

A meeting may be necessary to clarify the context of a claim. This more human approach can help avoid an impasse. The insurer will use the services of agents trained in this regard or rehabilitation professionals.

Independent Medical Expertise

The insurer may request, at its expense, that the insured be evaluated by a medical specialist of its choice. This evaluation is done by an independent physician who is not employed by the insurer. Refusal to undergo a medical evaluation may result in termination of benefits.

Due to the difficulty in obtaining a consultation with a specialist, the insurer uses this tool to provide the attending physician with a specialist's opinion and treatment options. A copy of the medical expert's report is sent to the attending physician, who may, at his or her discretion, comment on the expert's report.

Insured persons who want to obtain a copy of the specialist's report will be invited to request a copy from their attending physician, who will be able to explain the content to them.

Rehabilitation Services

Services not covered by the insurer's disability benefits may sometimes be provided at the insurer's expense with a view to facilitating recovery and an active life.

4. Benefits

4.1 Payment of Benefits

Monthly benefits are payable at the end of each month following the end of the waiting period, provided that the insurer accepts the disability. Refer to the Waiting period section (page 45).

Payments—except for the first and last—normally cover a full calendar month. They are generally issued on the second Friday of each month in order to be mailed the following week. Regardless of the benefit payment method, a benefit statement will be systematically sent to the insured.

Note that the payment of benefits may be delayed if the insurer has requested additional information but has not yet received it.

4.2 Indexation of Benefits

If the insured chose this option during the application process, the insurer will index the benefits paid on the first (1st) of January of the year that follows the end of the first twelve (12) months of benefits.

Indexation is generally based on the consumer price index (CPI) publish by Statistic Canada. Some of the insurer's old contracts instead use the rate published by the Canada Pension Plan (CPP) or the Régie des rentes du Quebec (RRQ). The applicable rate is stipulated in the insurance contract.

Canada Pension Plan and Régie des Rentes du Quebec

These plans provide for payment of a benefit in the event of a severe and prolonged disability that prevents the insured from engaging in any gainful employment.

Benefits paid by the CPP or the RRQ are deducted from disability benefits. However, it is important to note that the insurer takes into account only the amount initially granted by the CPP or the RRQ and any benefits for the children of a disabled contributor are not included.

Direct Deposit

The insured can decide to have disability benefit payments deposited directly into his or her bank account. The insurer recommends this payment method, which allows the insured to use the funds as soon as they are transferred, thereby avoiding any delayed or lost mail. Refer to the form included in the Claimant's guide – Disability insurance.

Note that direct deposit is not available if the claim concerns a request for a premium waiver or a benefit used to repay a creditor, in which case payments are made directly to the creditor.

5. Review of a Decision

If the insured does not agree with the insurer's decision and has sent all the documents available to support his or her claim, he or she may request a review by writing to:

Blue Cross/Canassurance
Claims Management
550 Sherbrooke Street West, Suite B9
Montréal, QC H3A 3S3

6. Contract Clauses

To ensure that the insured understands the extent of his or her coverage, it is important to explain the scope of certain contract clauses. The following clauses are especially important.

6.1 Date of Disability

The date of disability corresponds to the first full day of total disability. It must be after the last day worked. For the purposes of the insurance contract, the date of the first medical consultation after cessation of work is generally the date of commencement of disability. The waiting period provided for in the contract is calculated based on this date.

6.2 Waiting Period

The waiting period refers to the total disability period in which no benefit is payable. This period is indicated in the summary of benefits for the disability coverage or is specified in the policy wording on premium waivers.

The waiting period is an uninterrupted period of total disability, but some contracts allow more than one total disability period to be combined in order to meet waiting period requirements. Details will be provided in the policy.

6.3 Eligibility and Exclusion Clauses

Proof of Disability
The existence of a medical condition or a diagnosis does not in itself constitute proof of the insured's inability to work.

Disability is determined based on two factors:

- The insured's temporary or permanent incapacity due to illness or accident.
- The requirements of his or her job during tenure of the job or subsequently of any gainful employment consistent with his or her training, education, and experience.

To better understand the impact of the medical condition on the insured, the insurer may regularly request additional medical information or information on the insured's duties.

Impaired Driving

Contracts provide for an exclusion in the case of impaired driving. When a claim is filed after a traffic accident, the insurer must obtain complete medical records in order to verify the exclusion.

Pre-existing Conditions

Insurance contracts issued without a prior medical examination carry exclusions for pre-existing conditions. A pre-existing condition is a medical condition (diagnosed or undiagnosed) that the insured suffered from or showed symptoms of prior to the effective date of the policy.

The insured will not be entitled to benefits if he or she has, in the twelve (12) months prior to the effective date of his or her policy, consulted a health professional, undergone examinations, or been prescribed any drugs or treatments for the condition.

The pre-existing condition exclusion no longer applies if the policy has been in force for at least twelve (12) months depending on the type of contract.

If the insured files a claim that starts during this exclusion period, his or her medical history will be verified. This may delay the decision because the insurer must contact the insured's previously consulted physicians. The insured will be notified if such a delay occurs.

Incontestability

Most insurance contracts are issued based on the medical information provided by the insured during the application process.

If a disability occurs less than (2) years after the effective date of the contract, the insured's medical history will be verified to confirm the accuracy of the information provided. This may delay the decision because the insurer must contact the insured's previously consulted physicians. The insured will be notified if such a delay occurs.

6.4 Financial Clauses

Cancellation of Automatic Increases

Insureds who had chosen this option will no longer be entitled to automatic increases during their disability. Automatic increases will stop while the initial claim for benefits is under review. Any overpaid premiums related to automatic increases during disability will subsequently be reimbursed to the insured.

Dividends

Dividends are not deemed to be insurable earned income. If a business owner is paid dividends instead of a salary, the insurer will take into account the net profit of his or her company on a prorated basis according to the shares the insured holds to determine his or her earned income. Previous years are not taken into account.

Rental Income

Rental property income is not deemed to be insurable earned income. The insurer will not take this income into account in applying benefit reduction and coordination clauses.

Waiver of Premium

If a disability claim is filed, the insurer will automatically process the premium waiver for coverages including this benefit. However, if the policy does not include disability coverage, a specific premium waiver application must be submitted. The forms included in the Claimant's guide – Disability insurance may be used for this purpose.

Taxation of Benefits

When the applicant has selected a taxable benefit in the application, the insurer deducts federal and provincial taxes directly from the monthly benefit. Tax receipts will be issued at the end of the year.

Integration and Coordination of Benefits

The initial benefit payable by the insurer cannot exceed 100% of the insured's personal after-tax net income (90% of his or her personal pre-tax income if the benefits are taxable).

If the insured has multiple sources of disability benefits, the insurer may integrate and coordinate the benefits:

- The benefits paid by public insurance plans will be subtracted directly from the benefit paid by the insurer.
- The benefit will also be reduced if the insured's total disability benefit from both public and private plans exceeds 100% of his or her pre-disability net income. If the insured's benefit is taxable, this limit will be 90% of the pre-disability gross income.

If the insured submitted proof of income with the application, this income will be used for calculation purposes. However, the insured may provide proof of his or her pre-disability income if this is to his or her advantage, but the benefit amount cannot exceed the insured amount.

Note that any disability benefits paid to the insured's creditors, such as insurance on a mortgage or automobile loan, are not included in the calculation for the integration or coordination of benefits. The insured remains responsible of making regular payments to the creditors and must negotiate an arrangement with them to obtain reimbursement of benefits paid by the insurer.

Waiver of Premium

The insured must continue to pay premiums even if he or she files a claim or applies for a waiver with the insurer. Once a premium waiver is accepted, any overpaid premiums will be reimbursed.

Some insurance benefits do not include a premium waiver clause and premiums will continue to be billed during the disability.

It is important to note that the insurer does not deduct the premiums from the benefits payable to the insured.

6.5 Obtaining a Copy of the File

The insured can obtain a copy of his or her file by making a written request to the insurer. Handling charges and some restrictions may apply.

The insurer sends the insured's attending physician a copy of the medical expert's report(s), which he or she requires for analysis purposes. The insured can obtain a copy of the report(s) from his or her physician, who may, if he or she deems it appropriate, explain the content to the insured.

Note that the insurer cannot send an insured's file to a financial advisor, even with specific authorization from the insured, in accordance with the Act respecting the distribution of financial products and services:

37. "No information of a medical or lifestyle-related nature received from a client may be disclosed by an insurer to a firm offering both credit and insurance, even with the authorization of the client."

Claims – Life Insurance

1. Role of the Analyst

The analyst receives life insurance benefit claims, carries out the necessary follow-up and verification, and settles the claims while taking into consideration any exclusion on the contract.

2. Initial Claim for Benefits

2.1 Submitting a Claim

Notice and Forms

It is important to notify the insurer as soon as possible to start the claims process, either by telephone or email. Refer to the Contact information (p. I) section.

Upon receipt of the notice, the insurer will send the required form to the beneficiary or liquidator.

Claim Period

The completed claim must be submitted to the insurer as soon as possible. If the beneficiary or executor is unable to provide all the documents when the claim is submitted, he or she should still contact the insurer.

Any claim for benefits submitted within three (3) years after an insured's death will be considered within the claim period and will be analyzed.

2.2 Required Documents

The initial claim for benefits consists of the following documents:

- Claimant's statement
- Authorizations
- Statement of physician who certified the death
- Death certificate

If no beneficiary has been designated on the insurance policy, the claimant must also attach the following documents:

In Quebec

- Copy of the last will as well as the will search certificate from the Chambre des Notaires and Barreau du Quebec.
- If there is no will, a copy of the marriage contract.

In Ontario

- Copy of the last will and copy of the certificate of appointment of estate trustee with a will.
  OR
- Certificate of appointment of estate trustee without a will.

Claimant's Statement

This form must be completed and signed by each of the beneficiaries on the policy.

If there is no beneficiary, the policy product is part of the insured's succession and the form must be completed and signed.

In Quebec

> By the executor

In Ontario

> By the estate trustee

Consent

The authorizations must be signed and dated by the beneficiary or by the executor or estate trustee in order to start processing the claim. An initial claim without authorizations duly dated and signed will be deemed incomplete and this will entail a delay in the claim process.

Statement of Physician

This form must be completed and signed by the physician who certified the death.

Note that the physician's fees to complete the form are covered by the beneficiary.

Death Certificate

Original documents are required but may—upon request—be returned to the claimant depending on the amount of the benefit.

Table 2.2.1 Required Documents

Less than $50,000	More than $50,000
• Original attestation issued by a funeral home OR • Original death certificate issued by the registrar of civil status OR • Original act of death issued by the registrar of civil status	• Death certificate issued by Ontario's Office of the Registrar General or the Directeur de l'état civil du Quebec

2.3 Useful Links

Death settlements are complex. Here are a few useful links to help beneficiaries in the process:

Canada Revenue Agency

> What to do following a death

Government of Quebec

> What to do in the event of death

Government of Ontario

> What to do when someone dies

Justice Québec

> Successions

Retraite Québec

> Death

Service Canada

> Following a death

2.4 Decision of the Insurer

Upon receipt of the life insurance claim, the insurer will send a notice of receipt to the claimant.

Once the claim has been analyzed by the Claims Department, the claimant will be informed in writing of the initial decision, i.e., acceptance, denial, or further investigation.

If any other documents are needed to process the claim, the claimant will be notified.

Note that a copy of any correspondence will be forwarded to the advisor.

3. Life Insurance Benefits

Multiple Beneficiaries
If the insured has not indicated a specific distribution of the benefit amount among the various beneficiaries, the benefit will be divided equally among all beneficiaries.

Interest
Interest is paid on any benefit paid more than thirty (30) days after the date of death. Statements for tax purposes are issued when the interest amount is $50 or more.

Taxation of Benefits
Life insurance benefits are not taxable.

Direct Deposit
Note that direct deposit is not available for the payment of life insurance benefits. A cheque will be issued to the beneficiary or beneficiaries.

4. Review of the Decision

If the beneficiary does not agree with the insurer's decision and has sent all the documents available to support his or her claim, he or she may request a review by writing to:

Quebec
Blue Cross/Canassurance
Claims Management
550 Sherbrooke Street West, Suite B9
Montreal, QC H3A 3S3
claimslife.disability@qc.bluecross.ca

Ontario
Ontario Blue Cross
P.O. Box 4433, Station A
Toronto, ON M5W 3Y7
claimslife.disability@ont.bluecross.ca

5. Contract Clauses

5.1 Eligibility and Exclusion Clauses

To ensure that the insured understands the limitations and exclusions of coverage, it is important to explain the scope of certain contract clauses. The following clauses are especially important.

Pre-existing Conditions

Insurance contracts issued without a prior medical examination carry exclusions for pre-existing conditions. A pre-existing condition is a medical condition (diagnosed or undiagnosed) that the insured suffered or showed symptoms of prior to the effective date of the policy.

A life insurance benefit cannot be paid if, for the specific condition, the deceased insured had, in the twelve (12) months preceding the effective date of the policy, consulted a health professional, undergone examinations, or been prescribed any drugs or treatments.

This exclusion generally no longer applies if the policy has been in force for at least twelve (12) months.

If a claim is submitted within the exclusion period, the claimant's medical history will be verified. This may delay the decision, since the insurer must contact the insured's previously consulted physicians. Note that the claimant will be informed if such delay occurs.

Incontestability

Most insurance contracts are issued based on medical information provided by the insured during the application process.

If a death or disability occurs less than two (2) years after the effective date of the contract, the claimant's medical history will be verified to confirm the accuracy of information provided. This may delay the decision, since the insurer must contact the insured's previously consulted physicians. Note that the claimant will be informed if such a delay occurs.

Impaired Driving

Contracts provide for an exclusion in the case of impaired driving. When a claim is filed after a traffic accident, the insurer must obtain complete medical records in order to verify the exclusion.

Suicide Clause

When a death results from a suicide that occurred within the first twenty-four (24) months (or twelve [12] months depending on the product) of the effective date of the life benefit, the benefit is not payable, regardless if the insured is of sound mind or not.

5.2 Obtaining a Copy of the File

The beneficiary can obtain a copy of the file by making a written request to the insurer. Handling charges and some restrictions may apply.

Note that the insurer cannot send an insured's file to a financial advisor, even with specific authorization from the insured, in accordance with the Act respecting the distribution of financial products and services:

37. "No information of a medical or lifestyle-related nature received from a client may be disclosed by an insurer to a firm offering both credit and insurance, even with the authorization of the client."

Claims – Health/Dental

1. Role of the Analyst

The analyst receives health and dental insurance benefit claims, carries out the necessary follow-ups and verifications, and settles the claims while taking into account any exclusions, deductibles, maximums, and coinsurance.

2. Determining Benefits

2.1 Calculating Payments

Maximum reimbursement - deductible - coinsurance = payment

2.2 Maximum Reimbursement

The maximum reimbursement is set out in the contract for a fixed period and varies by plan.

2.3 Deductible

The deductible is the base amount the insured must pay that is not covered by the insurer.

2.4 Coinsurance

Some benefits do not cover 100% of incurred expenses so the insurer will only repay a certain percentage of those expenses and the insured is responsible for the balance.

2.5 Coordination of Benefits

The coordination of benefits is when multiple insurers cover the same risk. The amount covered by the second insurer is deducted from the maximum reimbursement because the purpose of the insurance is not to earn the insured a profit but to reimburse the insured for incurred expenses.

3. Health/Sickness Insurance

Health/sickness insurance is considered supplemental because it reimburses incurred expenses that are either not covered or only partially covered by provincial insurance plans.

3.1 Coverage

Health/sickness insurance usually covers:

- Hospitalization expenses
- Professional healthcare services
- Ambulance services
- Medical examinations
- At-home nursing care
- Cost of buying prostheses and medical devices
- Wheelchairs
- Eyeglasses and contact lenses
- Prescription drugs (optional coverage)

3.2 Restrictions

Exclusions

If the contract specifies an exclusion, the expenses for that exclusion are not eligible. Any pre-existing condition may be excluded depending on the contract terms. However, it is critical that any suspected or diagnosed conditions are fully disclosed at the time of application, otherwise the contract could be cancelled as of its issue date for a claim that was otherwise valid.

Medically Necessary Expenses

To be reimbursable, eligible medical expenses must be considered medically necessary.

Massage Therapy Expenses

A doctor's prescription is always required for massage therapy expense reimbursement claims. (A prescription is valid for twelve (12) months from the date it is signed).

Podiatry Expenses

In Quebec, only expenses incurred with a podiatrist who is a member of Ordre des podiatres du Quebec may be reimbursed according to the podiatry consultation terms in the contract. Podologists are therefore not covered.

In Ontario, expenses incurred with a podiatrist or podologist who is a member of its relevant association are covered.

Psychology Expenses

Only expenses incurred with a psychologist who is a member of Ordre des psychologues du Quebec or of the College of Psychologists of Ontario may be reimbursed according to the psychology consultation terms in the contract.

Eye Exam

For insureds under age 65, an eye exam is covered for a total of $50 per 24 months, independent of any condition that could require more frequent exams.

Claim Deadline

Claims must be submitted within 12 months of the service date.

Required Information on Submitted Receipts

Receipts not related to prescription drugs must be on the letterhead of the person or company that provided the service and clearly indicate the following:

- Patient's name
- Service date(s)
- Service description
- Cost of each service rendered
- Healthcare professional's name
- Type of healthcare professional
- Healthcare professional's licence or registration number

4. Dental Care Insurance

It is recommended to send us a pre-determined treatment plan before having any major dental work done so you will know what is covered.

4.1 Coverage

Only standard reasonable expenses from services performed by a dentist, dental hygienist, or denturist with a degree are eligible.

4.2 Restrictions

- Orthodontic costs are not covered.
- Root canal expenses are covered up to the maximum set out in the contract.
- Expenses for installing a crown are reimbursable only with the Blue Choice, Basic Blue Choice and Blue Vision plans.
- The cost of buying or replacing dentures is only covered with the Blue Choice, Basic Blue Choice and Blue Vision plans.
- Services covered under the contract include: minor adjustments, rebasing and relining, cleaning and polishing of dentures.

Glossary

Accidental death insurance
A form of life insurance by which a beneficiary is paid an indemnity in the event the insured dies as a result of an accident.

Annuity
Indemnity paid to the insured on a regular schedule.

Attained age premium
Premium set based on the insured's age group at the time coverage takes effect, and readjusted based on the insured's age at every renewal.

Automatic benefit increase
Option offered for some plans by which the insured amount increases automatically every year on the contract renewal date.

B2B (Business to Business)
Website our partners can use to sell health or travel insurance online.
https://www.info-partenaires.ca/b2b/login.faces

B2C (Business to Client)
Website our clients can use to take out health or travel insurance online.

Backdating a contract
Modifying the effective date of a policy to an earlier date to save the age of the person to be insured. A policy cannot be backdated more than three months and never to make an insured eligible for coverage.

Beneficiary
Person designated by the policyholder, or in some cases the contract itself, to receive the indemnity in the event the covered risk materializes. Only life, death, and critical illness insurances require a beneficiary.

Benefit
Payment made by the insurer to indemnify the insured or the beneficiary when a risk materializes.

Benefit period
Maximum period during which benefits are paid in the event a covered risk materializes.

Changing the effective date
Modifying the effective date of a policy so that coverage begins on a later date. (See Backdating a contract).

Claim
Request for payment submitted to the insurer after a covered risk materializes.

Conversion
Gradual transition of one coverage to another to meet the insured's changing needs (Tangible).

Conversion privilege
Option to take out other coverage when existing coverage expires without having to go through Underwriting analysis again.

Coordination of benefits
Organizing benefits paid by different insurers covering the same risk for the same insured in order to indemnify the insured as fully as possible without the insured making a profit.

Coverage (Benefit)
Commitment by the insurer to cover, according to the terms set out in the contract, a given risk and to reimburse the insured in the event the risk materializes.

Deductible
Base amount not covered, routinely deducted from the reimbursement of certain expenses covered by the insurance contract.

Effective date
The date, down to the hour, the insurance contract takes effect.

Endorsement
Document signed by the policyholder confirming amendments made to the contract and considered an integral part thereof.

Exclusion
Conditions and/or treatments not covered by an insurance policy because they were already present before the coverage came into force or because the risk that the condition will develop or the treatments will be required exceeds the insurer's insurability standards.

Exclusion for pre-existing conditions
Clause according to which, with respect to any amount granted without a Health statement (Association or SME plan amount), no benefit will be payable for a claim pertaining to an event that occurs within the first twelve (12) months following the date the insurance takes effect if it is the result of an illness or accident for which the insured received medical treatment during the twelve (12) months preceding the date the insurance took effect.

Extra premium
Additional amount—usually a percentage—added to the premium because of increased risk.

Financial underwriting
Insurable amount given the financial situation of the person to be insured.

Grace period
Additional forty-five (45) days given to the payor to pay the premium beyond the premium due date.

Guaranteed leveled premium
Premium set based on the insured's age group at the time coverage is issued and that will never go up. This type of premium is only available for certain benefits (Tangible).

Incontestability
Contract clause by virtue of which the insurer waives the right to investigate any misrepresentation discovered beyond a period of two (2) years after the contract takes effect.

Income enhancement
Percentage applicable to the net income of the person to be insured in determining the insurable amount, without exceeding the gross income.

Indexed benefit
After a disability of over twelve (12) months, benefits paid for a total disability in progress are increased on January 1st of each year according to the Consumer Price Index published annually by Statistics Canada.

Individual insurance
Type of insurance whose contract protects an insured or a family against a given risk.

Insurability
All of the conditions taken into account in determining whether coverage will be possible under an insurance contract.

Insurance application
Document signed by the policyholder detailing the insurance request.

Insurance certificate
Document issued by the insurer as proof that there is a contract covering one or more given risks.

Insurance contract
A contract binding the insurer and the insured by which, in return for the payment of a premium, the insurer will indemnify the insured in the event a determined risk materializes.

Insurance policy
Document signed by the insurer and the policyholder defining and confirming the validity of the coverage and contract terms and conditions.

Insured
The person whose life, health, physical safety, or disability is subject to the risk covered by the insurance policy.

Lapse
Termination of insurance coverage for non-payment of the premium within the agreed-upon deadlines.

Leveled premium
Premium set based on the insured's age group at the time coverage is issued and that will not go up every year at renewal. However, the base rates could increase according to economic forecasts, so the premiums would as well.

MIB (Medical Information Bureau)
A not-for-profit corporation whose members are life and disability insurance companies that shares information on behalf of its member insurers.

Misrepresentation
A false statement—whether intentional or not—that could impact the insurability of the person to be insured and result in an exclusion or refusal.

Occupational category
Group of occupations within an economic sector used to determine occupational risk.

Policyholder
The person who submits an insurance application and is the only one to have the right to amend and/or cancel the insurance policy.

Pre-authorized debit agreement
A form by which the payer authorizes a premium to be automatically withdrawn from a designated bank account on a regular basis.

Pre-existing condition
A condition for which a diagnosis was given or whose symptoms were observed before the insurance policy entered into effect. Insurance policies do not cover pre-existing conditions.

Premium (annual, monthly, quarterly)
Amount paid according to a predetermined schedule in exchange for insurance contract coverage.

Premium due date
The date on which the premium is to be paid under the contract.

Reinstatement
Option of reopening a contract that lapsed or was cancelled by the client. The terms and conditions set out in the contract apply.

Renewal
Resumption of certain contracts (depending on the product) on the contract anniversary date or on the loan period end date.

Rightful claimant
The person who legally has the right to an insurance claim due to a family or other personal relationship.

Risk
Damage or potential damage against which the insured would like to be covered.

Sponsorship
Obligatory process requiring all new brokers to be sponsored for two years before they can be licensed.

Term life insurance
Insurance by which the policy beneficiary is paid an indemnity in the event the insured dies before the coverage expiry date. The money invested will be lost if the insured is still living on the coverage expiry date.

Waiting period
Period during which no benefit is payable in the event a risk materializes.

Waiver of premium
A benefit by which, in certain cases, no premium is required but the coverage set out in the contract is maintained.