Application

CONTRACT NO. | BLUE CROSS USE ONLY | SPOUSE APPLICATION NO. | APPLICATION NUMBER

Reset

☐ Association Program ☐ Express Plan ☐ Association Program / Express Plan

Name of the association

☐ New enrolment ☐ Change Please indicate the number of your existing policy:

Representative information

NAME OF FIRM | REPRESENTATIVE (ADMINISTRATOR) | % | REPRESENTATIVE CODE

OTHER REPRESENTATIVE (IF APPLICABLE) | % | REPRESENTATIVE CODE

1 PERSONAL INFORMATION

NOTE: The orange fields must be completed PRIOR TO PRINTING the application.

1.1 PRIMARY INSURED

IMPORTANT: You must be a beneficiary as defined by the health and hospital insurance legislation in your province of residence.

Identification

Primary insured

LAST NAME | FIRST NAME

Date of birth: DAY | MONTH | YEAR | AGE

Sex: ☐ M ☐ F

Civil status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Common-law

Language choice ☐ English ☐ French

Place of birth: COUNTRY, PROVINCE

If you are not a Canadian citizen, are you: ☐ Permanent resident (Landed immigrant) ☐ Other (please specify):

Smoker ☐ Yes ☐ No

Do you accept to receive the offers and newsletters from Blue Cross®? Note that you can unsubscribe at any time. ☐ Yes ☐ No

ADDRESS, NO. | STREET | APT. | CITY | PROVINCE | POSTAL CODE

TELEPHONE | MOBILE | E-MAIL

Occupation

Principal occupation

FUNCTIONS | DATE OF HIRING | % OF TIME

Employer/Business

NAME OF EMPLOYER/BUSINESS | NATURE OF BUSINESS

EMPLOYER/BUSINESS TELEPHONE | EMPLOYER/BUSINESS E-MAIL

ADDRESS, NO. | STREET | SUITE | CITY | PROVINCE | POSTAL CODE

EMPLOYEE TELEPHONE AT WORK | EMPLOYEE MOBILE AT WORK | EMPLOYEE E-MAIL AT WORK

Do you work at least 20 hours a week? ☐ Yes ☐ No

Do you work at least 8 months a year? ☐ Yes ☐ No

Other occupation

Other occupation (if applicable)

FUNCTIONS | DATE OF HIRING | % OF TIME

Salary or earnings

Annual salary or net annual earnings

AFTER EXPENSES AND BEFORE TAXES

QUÉBEC BLUE CROSS®

1.2 FAMILY, COUPLE OR SINGLE-PARENT COVERAGE

If you have chosen a benefit that includes family, couple or single-parent coverage, please complete this section:

Spouse

LAST NAME | FIRST NAME | Date of birth: DAY | MONTH | YEAR | AGE | ☐ M ☐ F (SEX)

Dependent children

	LAST NAME	FIRST NAME	RELATIONSHIP	Date of birth: DAY	MONTH	YEAR	AGE	SEX
1.								☐ M ☐ F
2.								☐ M ☐ F
3.								☐ M ☐ F
4.								☐ M ☐ F

2 POLICYHOLDER INFORMATION (if different from Primary insured)

Identification

Policyholder

LAST NAME | FIRST NAME

Date of birth: DAY | MONTH | YEAR | AGE

Sex: ☐ M ☐ F

If the Policyholder is a business

NAME OF THE COMPANY

ADDRESS, NO. | STREET | APT. | CITY | PROVINCE | POSTAL CODE

TELEPHONE (HOME) | TELEPHONE (WORK) | E-MAIL

Language choice
☐ English ☐ French

3 BENEFICIARY OR BENEFICIARIES

Any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.

Beneficiary or beneficiaries

	LAST NAME	FIRST NAME	RELATIONSHIP	% OF SHARES	
1.					☐ Revocable ☐ Irrevocable
2.					☐ Revocable ☐ Irrevocable
3.					☐ Revocable ☐ Irrevocable

4 METHOD OF PAYMENT

☐ **Credit card** (Monthly or annual)

☐ AMEX
☐ MASTERCARD
☐ VISA

Payment frequency: ☐ Monthly ☐ Annual

Card number

Expiration date: MONTH | YEAR

SIGNATURE OF CARDHOLDER

FIRST AND LAST NAME (PLEASE PRINT)

☐ **Pre-authorized debit** (Monthly)

Please sign the pre-authorized debit (PAD) agreement on page 3 and attach a void cheque.

☐ **Cheque** (Annual)

Please attach a cheque payable to BLUE CROSS CANASSURANCE.

A cheque in the amount of $ _____ representing the annual premium payment is attached herewith.

For every method of payment

Do you authorize Blue Cross Canassurance to charge the first premium before the assessment of your application? ☐ Yes ☐ No

5 PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

INSURED'S NAME | CONTRACT NO.

BLUE CROSS USE ONLY | BLUE CROSS USE ONLY

5.1 PAYOR INFORMATION

Last and first names (please print)

Account holder

LAST NAME

FIRST NAME

ADDRESS, NO. | STREET | APT. | CITY | PROVINCE | POSTAL CODE

TELEPHONE | MOBILE | E-MAIL

Joint account holder

LAST NAME

FIRST NAME

5.2 BANK ACCOUNT INFORMATION

Type of service: personal

Financial institution

NAME | INSTITUTION NO. | BRANCH TRANSIT NO. | ACCOUNT NO.

ADDRESS, NO. | STREET | SUITE | CITY | PROVINCE | POSTAL CODE

5.3 AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1. I, the undersigned, hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $ _____, for payment of my insurance contract. If no date is entered, I understand that the date may be determined by the Insurer without giving me prior notice.

   Desired withdrawal date: _____
   (excluding the 29th, 30th and 31st).
   I have attached a void cheque ☐

   I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing for my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all preauthorized debits (PAD) withdrawn from my account are fixed or variable-amount personal PADs.
2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to send me prior notice of thirty (30) days only for the renewal of my policy.
3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution. I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.
4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten (10) business days prior to a PAD.
5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service department at **1-800-363-3958.**
   I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD.
6. I understand that I may revoke this authorization at any time subject to providing ten (10) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit **www.payments.ca**.
7. I understand that the Insurer may cancel this Agreement upon thirty (30) days written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.
8. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.payments.ca**.

5.4 SIGNATURE

SIGNATURE OF THE ACCOUNT HOLDER

FIRST AND LAST NAME (PLEASE PRINT)

DATE (DD/MM/YYYY)

SIGNATURE OF JOINT ACCOUNT HOLDER (IF APPLICABLE)

FIRST AND LAST NAME (PLEASE PRINT)

DATE (DD/MM/YYYY)

6 DECLARATION – EXPRESS PLAN

6.1 DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT

INITIALS OF PRIMARY INSURED

1. The person to be insured hereby declares that he/she has not had a critical illness insurance application or reinstatement of insurance declined, postponed or accepted with special conditions during the past two (2) years.
2. The person to be insured hereby declares that he/she has never consulted a doctor, been hospitalized, demonstrated symptoms of or presented health problems, taken drugs or received a treatment for any of the following conditions:
   a) **Cardiovascular disorders:** heart attack, angina, arrhythmia, pacemaker, defibrillator, high blood pressure*, heart failure, bypass, angioplasty, valvulopathy or valve replacement, aortic aneurysm, heart transplant, peripheral vascular disease or any other heart surgery
   b) **Chronic obstructive pulmonary disorders:** asthma, emphysema, chronic bronchitis, lung transplant
   c) **Neurological disorders:** stroke, transient cerebral ischemia (TCI)
   d) **Insulin-dependent diabetes:** diabetes treated with insulin
   e) **Kidney failure, kidney transplant**
   f) **Gastrointestinal disorders:** cirrhosis, hepatitis, ulcer, internal bleeding, liver transplant, surgery for bowel obstruction
   g) **Cancer or malignant tumour**

   * If the person to be insured reports having high blood pressure that is well controlled according to the attending physician, with medical monitoring and a blood pressure reading of less than 170/100, the person to be insured may sign the Declaration for critical illness assistance benefit.
3. The person to be insured declares that he/she has not undergone in the last five (5) years a course of treatment for detoxification (closed or open treatment) following alcohol or drug consumption, and has not had hard drug usage in the last five (5) years such as: opium, heroine, morphine, codeine, demerol, barbiturates, amphetamines, cocaine, hallucinogens or anabolic steroids, or methadone, prescribed or not by a doctor.
4. The person to be insured hereby declares that he/she is not awaiting any medical test results and he/she is not under medical investigation.

6.2 DECLARATION FOR MONTHLY INDEMNITY DUE TO ILLNESS EXPRESS BENEFIT

INITIALS OF PRIMARY INSURED

The person to be insured hereby declares that he/she has not, for the last three (3) years:

a) had an insurance application declined, postponed or accepted with special conditions
b) been treated or consulted for use of alcohol or drugs
c) been hospitalized twice or more (except for pregnancy)
d) been treated or taken medication for cancer, tumor, cardiovascular disorders or neurological disorders or psychological disorders, diabetes, kidney failure, high blood pressure superior to 170/100 (maximal indicator exceeds 170 or minimal indicator exceeds 100)

6.3 DECLARATION FOR ALL EXPRESS PLAN BENEFITS

INITIALS OF PRIMARY INSURED

1. On the date of signing this application, each person to be insured declares the following:
   a) He/she is not disabled
   b) He/she is not hospitalized or waiting to be hospitalized
   c) He/she does not have or has never been diagnosed with breast cancer
   d) He/she did not have or has never been diagnosed or been treated for any other type of cancer in the past five (5) years
   e) He/she did not have or has never been diagnosed with AIDS or any form of pre-AIDS
2. Each person to be insured hereby declares that all answers given in this application and in any other document which, by agreement forms a part thereof are true and complete. We, the persons to be insured, understand that any omission or misrepresentation statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.
3. Each person to be insured hereby confirms that he/she has been informed of all statements recorded in this application.
4. The Primary insured asks that Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, issue a contract as specified herein.
5. This declaration offers no guarantee of insurance.

6.4 SIGNATURE

The Express Plan benefits shall take effect one minute after midnight on the day following the signing of the application, provided that the first premium is paid in full.

No representative is authorized to establish or modify the Insurer's contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of the Insurer.

Signed in _____ this _____ day of _____

CITY | DAY | MONTH, YEAR

SIGNATURE OF THE PERSON TO BE INSURED (Policyholder if the person to be insured is under 16 years of age)

SIGNATURE OF SPOUSE

SIGNATURE OF REPRESENTATIVE

7 ASSOCIATION FORM

7.1 DECLARATION

INITIALS OF PRIMARY INSURED

1. Each person to be insured hereby declares the following:

a) That he/she has not been diagnosed or has consulted a health professional for one of the following conditions:

- Musculoskeletal Disorder (that caused the applicant to miss work in the last twelve (12) months)
- Spine Diseases (causing the applicant to miss more than five (5) business days of work in the last twenty-four (24) months)
- Alzheimer's Disease
- Thoracic or Abdominal Aortic Aneurysm
- Rheumatoid Arthritis or Psoriatic Arthritis
- Breast Cancer
- Cancer (diagnosed in the past 5 years, excluding basal cell carcinoma of the skin and cervical cancer in situ)
- Liver Cirrhosis
- Diabetes Mellitus (type 1 or 2)
- Epilepsy (Grand mal, attack within 6 months)
- Chronic Fatigue Syndrome
- Fibromyalgia
- Hepatitis (B or C)
- Chronic Renal Failure
- Transient Ischemic Attack
- Leukemia
- Lymphoma
- Systemic Lupus Erythematosus
- Heart Diseases (Angina Pectoris, Myocardial Infarction, Coronary Artery Bypass, Coronary Artery Angioplasty, Acute Coronary Syndrome) or Valvular Heart Disease (Including all Valvular Heart Disease)
- Inflammatory Intestinal Disease (causing the applicant to miss more than fifteen (15) business days of work in the last twenty-four (24) months)
- Chronic Obstructive Pulmonary Disease
- Peripheral Vascular Disease
- Chronic Pancreatitis
- Parkinson's Disease
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis
- Acquired Immune Deficiency Syndrome (AIDS)
- Myeloproliferative Syndrome
- Organ Transplants
- Psychological or Psychiatric Disorders (currently under treatment or having required one year or more of treatment in the past)
- Drug Dependence
- Alcohol Abuse

b) Not being hospitalized or disabled on the date of the signature of the present application.

c) Never has had an application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions.

2. Each person to be insured acknowledges the following:

Exclusion for pre-existing conditions (applicable for the Term life 65, Life hybrid, Monthly indemnity due to accident and illness, Disability due to accident and illness, Disability hybrid and the Overhead expenses benefits).

With regard to any amount granted with the Association Form declaration, no benefit will be payable for a claim relating to an event occurring within twelve (12) months following the effective date of coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed diagnostic tests in the twelve (12) month period preceding the effective date of coverage.

If the persons to be insured cannot sign this declaration, they must complete a telephone interview (Section 8 of the present application) or a complete health statement. Then, if the Insurer accepts the persons to be insured, the exclusion for pre-existing conditions will not apply.

7.2 SIGNATURE

No representative is authorized to establish or modify the Insurer's contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of the Insurer.

Signed in _____ (CITY)

this _____ (DAY)

day of _____ (MONTH, YEAR)

SIGNATURE OF THE PERSON TO BE INSURED
(Policyholder if the person to be insured is under 16 years of age)

SIGNATURE OF SPOUSE

SIGNATURE OF REPRESENTATIVE

7 ASSOCIATION FORM (CONTINUED)

7.3 DECLARATION FOR EXTENDED HEALTH BENEFIT WITH DRUGS

INITIALS OF PRIMARY INSURED

1. Over the last twelve (12) months, have those to be insured taken or currently take any medication?

Primary insured	Spouse	Children
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2. Have those to be insured ever been informed by a doctor that they are suffering from a chronic disease?

Primary insured	Spouse	Children
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the questions above, please provide details below:

Question no.	Person's first name	Details of diagnosis, treatment, medication and present condition	Date of each occurrence	Symptom duration	Duration of absence from work	Names and addresses of doctors and medical establishments

Each person to be insured hereby declares that all answers and explanations given in this form are true and complete.
Each person to be insured, understands that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.

7.4 SIGNATURE

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

SIGNATURE OF THE PERSON TO BE INSURED
(Policyholder if the person to be insured is under 16 years of age)

SIGNATURE OF SPOUSE

SIGNATURE OF REPRESENTATIVE

QUÉBEC BLUE CROSS®

To be given to the person to be insured

RECEIPT

This amount corresponds to the first premium.

Received the amount of:

AMOUNT

Date

DD/MM/YYYY

For the person to be insured:

FIRST AND LAST NAME

SIGNATURE OF REPRESENTATIVE

NOTICE

NOTICE REGARDING PERSONAL INFORMATION

By applying for our insurance product(s), you are consenting to our collecting, using and disclosing your personal information for the purpose of appraising your insurance application, confirming your coverage and/or benefits, and processing or paying your claims.

The personal information contained in this document will be kept on a confidential basis, in your Canassurance Hospital Service Association and/or Canassurance Insurance Company insurance file.

Your personal information will only be accessible by our employees and authorized representatives who require access to your file for the purposes set out above.

On written request, you may review the personal information in this file and require that your file be updated or corrected.

For additional information regarding the manner in which we collect, use, disclose and otherwise manage your personal information, please visit our website or write to us:

MANAGER, ACCESS TO INFORMATION
Blue Cross Canassurance
550 Sherbrooke Street West, Suite B-9
Montréal, Québec H3A 3S3
qc.bluecross.ca

NOTICE

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU AND EXCHANGE OF INFORMATION

Information regarding your insurability will be treated as confidential. The Insurer or the Insurer's reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
If you apply to another Bureau member company for life or health coverage, the Bureau, on request, will supply such company with the information about you in its files.

All insurers including Canassurance Hospital Service Association and/or Canassurance Insurance Company sometimes write investigative consumer reports in applying standards on processing of applications. The report generally includes information on those to be insured and their lifestyle.

Upon request from you, the Medical Information Bureau will arrange to disclose to you the information in your file, except for medical information, which will be given only to your doctor. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and ask to have it corrected.

The address of the Bureau's Information Office is as follows:

Medical Information Bureau
330 University Avenue, Suite 501
Toronto, Ontario M5G 1R7
Telephone: 416-597-0590
Fax: 416-597-1193

"MIB receives personal information and the collection, use and disclosure of such information is governed by the *Act respecting the Protection of Personal Information in the Private Sector* in Québec and all similar provincial or federal laws."

Therefore, MIB has agreed to protect such information in a manner that is substantially similar to the Insurer's privacy and security practices, and in accordance with applicable Québec and Canadian laws. As a U.S. based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws. If you have any questions about MIB's commitment to protect the confidentiality and security of your personal information, you may contact the MIB Privacy Department at **privacy@mib.com**.

FILL OUT ONLY:

☐ FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE ASSOCIATION PROGRAM
OR
☐ IF YOU CANNOT SIGN THE ASSOCIATION FORM DECLARATION (SECTION 7.2)

Have you selected the telephone interview in replacement of the health statement? ☐ Yes ☐ No
If so, please complete the following section.
If the client does not speak English or French, the telephone interview is mandatory.

8 TELEPHONE INTERVIEW

To optimize the interview process, please indicate in the chart below the best time for a specialist to call you for information about your health and lifestyle. Information obtained during the telephone interview is considered confidential information.

Please indicate the phone number(s) at which you prefer to be contacted:

Insured 1	Insured 2
TELEPHONE (HOME)	TELEPHONE (HOME)
TELEPHONE (WORK)	TELEPHONE (WORK)
MOBILE	MOBILE
Preferred language for the call:	Preferred language for the call:
LANGUAGE	LANGUAGE

Please indicate the most convenient moment for us to call you:

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2	INSURED 1	INSURED 2
9 AM - 12 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12 PM - 2 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2 PM - 4 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4 PM - 6 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6 PM - 9 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

INSURED 1: PRIMARY INSURED INSURED 2: SPOUSE

If you have completed the above section, Blue Cross will be responsible for the telephone interview process and will be accountable for obtaining all medical requirements.

Take note that you will be first contacted to set up a time for the interview, but that the interview itself will be done later at the agreed time and date.

FILL OUT ONLY:
FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE ASSOCIATION PROGRAM
OR
IF YOU CANNOT SIGN THE ASSOCIATION FORM DECLARATION (SECTION 7.2)

To be completed only if you wish to apply for disability insurance, monthly indemnity or overhead expenses.

9 OCCUPATION INFORMATION

9.1 EMPLOYEES, COMPANY OWNERS AND SELF-EMPLOYED

1. Do you want to provide proof of income:

☐ with your application ☐ when you make a claim

If the amount of insurance you are applying for is $3,500 or more OR you elect to submit proof of income with your application no matter what amount of insurance you are applying for, please provide complete financial evidence for the last two years.

2. Are you:

☐ an employee ☐ a company owner ☐ self-employed

3. Do you contribute to:

☐ Employment Insurance ☐ the CNESST

4. Professional titles or diploma:

5. How long have you been practicing this occupation?

6. If you have had this occupation for less than 1 year, please indicate previous occupation:

9.2 COMPANY OWNERS AND SELF-EMPLOYED ONLY

1. Are you the owner?

☐ Yes ☐ No

Shares:

PERCENTAGE (%)

2. Do you have firm contracts for the next 12 months?

☐ Yes ☐ No If yes, please specify:

3. Do you work from home?

☐ Yes ☐ No If yes, is your office accessible to the public? ☐ Yes ☐ No

Time working outside home:

PERCENTAGE (%)

4. Job duties – Please indicate the job functions and the percentage of time dedicated to carrying out each one of them:

Functions	Percentage of time (%)	Description of functions
Manual labour		
Management/Office		
Sales		
Supervision		
Locations		
Office		
Workshop/Warehouse		
On site		

FILL OUT ONLY:
FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE ASSOCIATION PROGRAM
OR
IF YOU CANNOT SIGN THE ASSOCIATION FORM DECLARATION (SECTION 7.2)

10 CONSENT

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

For purposes of evaluating and determining my eligibility and the eligibility of my dependent children for insurance products and benefits, I authorize any licensed physician, health professional, hospital, medical facility, insurance company, reinsurance company, the Medical Information Bureau (MIB), the Régie de l'assurance maladie du Québec or any other organization, agency, institution, broker, agent, employer, representative or person holding records or knowledge on myself or on my dependent children, including medical history, to give any such information to Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, its reinsurers, its auditors and to any organization or professional appointed by the Insurer in the processing of my request.

I hereby authorize the Insurer, or its reinsurers, to make a brief report of my personal health information to MIB to exchange information held by the Insurer with the aforementioned persons and organizations.

This authorization shall be valid throughout the duration of the contract.

A photocopy of this authorization is as valid as the original.

10.1 SIGNATURE

SIGNATURE OF THE PERSON TO BE INSURED
(Policyholder if the person to be insured is under 14 years of age)

SIGNATURE OF SPOUSE

FIRST AND LAST NAME (PLEASE PRINT)

SIGNATURE OF THE DEPENDENT CHILD
(14 years of age and over)

DATE (DD/MM/YYYY)

BLUE CROSS :: APPLICATION APPLICATION NUMBER

10 CONSENT

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

For purposes of evaluating and determining my eligibility and the eligibility of my dependent children for insurance products and benefits, I authorize any licensed physician, health professional, hospital, medical facility, insurance company, reinsurance company, the Medical Information Bureau (MIB), the Régie de l'assurance maladie du Québec or any other organization, agency, institution, broker, agent, employer, representative or person holding records or knowledge on myself or on my dependent children, including medical history, to give any such information to Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, its reinsurers, its auditors and to any organization or professional appointed by the Insurer in the processing of my request.

I hereby authorize the Insurer, or its reinsurers, to make a brief report of my personal health information to MIB to exchange information held by the Insurer with the aforementioned persons and organizations.

This authorization shall be valid throughout the duration of the contract.

A photocopy of this authorization is as valid as the original.

10.1 SIGNATURE

SIGNATURE OF THE PERSON TO BE INSURED
(Policyholder if the person to be insured is under 14 years of age)

SIGNATURE OF SPOUSE

FIRST AND LAST NAME (PLEASE PRINT)

SIGNATURE OF THE DEPENDENT CHILD
(14 years of age and over)

DATE (DD/MM/YYYY)

FILL OUT ONLY:
FOR ADDITIONAL AMOUNTS ABOVE THE ONES OFFERED WITH THE ASSOCIATION PROGRAM
OR
IF YOU CANNOT SIGN THE ASSOCIATION FORM DECLARATION (SECTION 7.2)

11 EFFECTIVE INSURANCE

Do you have any effective insurance or application currently under assessment (individual or group)?

☐ Yes ☐ No

Do you have any other insurance policy, including through your employer?

Life, disability, critical illness, long-term care or mortgage disability/life policy ☐ Yes ☐ No

If yes, please complete the table below:

Do you already have a Blue Cross policy?

☐ Yes ☐ No

If yes, please indicate the contract number:

Individual insurance

Name of Primary insured	Company	Type of contract/benefits*	Effective date	Insured amount

* Life, disability, critical illness, long-term care or mortgage disability and life

Group insurance

Name of Primary insured	Company	% of salary or fixed amount	Taxable
			☐ Yes ☐ No

Insurance replacement

If this application is to replace an existing policy or policies, please list the policy or policies below:

Company	Coverage	Termination date

11.1 DECLARATION

1. Each person to be insured hereby declares that all answers given in this application and in any other document which, by agreement forms a part thereof are true and complete. We, the persons to be insured, understand that any omission or misrepresentation statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.
2. Each person to be insured hereby confirms that he/she has been informed of all statements recorded in this application.
3. The Primary insured asks that Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, issue a contract as specified herein.
4. The Primary insured acknowledges receipt of the Notice regarding the Medical Information Bureau and exchange of information.

11.2 SIGNATURE

No representative is authorized to establish or modify the Insurer's contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of the Insurer.

Signed in _____ CITY

this _____ DAY

day of _____ MONTH, YEAR

_____ SIGNATURE OF THE PERSON TO BE INSURED
(Policyholder if the person to be insured is under 16 years of age)

_____ SIGNATURE OF SPOUSE

_____ SIGNATURE OF REPRESENTATIVE