

Application

CONTRACT NO.

SPOUSE APPLICATION NO.

APPLICATION NUMBER

BLUE CROSS USE ONLY

Name of SME

SMEPlan ExpressPlan SMEPlan/ExpressPlan

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

Representative information

REPRESENTATIVE (ADMINISTRATOR)	%	REPRESENTATIVE CODE	
NAME OF FIRM	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

Language choice

English French

Do you accept to receive the offers and newsletters from Blue Cross®? Note that you can unsubscribe at any time.

Yes No

Primary insured

LAST NAME				FIRST NAME					
Date of birth		Sex		Civil status					
DAY	MONTH	YEAR	AGE	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Common-law	
Place of birth				If you are not a Canadian citizen, are you:				Smoker	
COUNTRY, PROVINCE				<input type="checkbox"/> Permanent resident (Landed immigrant) <input type="checkbox"/> Other (please specify):				<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADDRESS, NO.	STREET	APT.	CITY	PROVINCE	POSTAL CODE				
TELEPHONE		MOBILE		E-MAIL					

Occupation

Principal occupation

FUNCTIONS		DATE OF HIRING	% OF TIME
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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
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Salary or earnings

Annual salary or net annual earnings

AFTER EXPENSES AND BEFORE TAXES



**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		Date of birth	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	FIRST NAME	DAY	MONTH
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		YEAR	AGE
		<input type="checkbox"/> M <input type="checkbox"/> F	SEX
Dependent children		Date of birth	
1. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		DAY	MONTH
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		YEAR	AGE
3. <input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	SEX
4. <input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	SEX
LAST NAME	FIRST NAME	RELATIONSHIP	SEX

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

1. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
LAST NAME	FIRST NAME	RELATIONSHIP	% OF SHARES	

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

Account holder

Joint account holder

Last and first names (please print)

LAST NAME

LAST NAME

FIRST NAME

FIRST NAME

ADDRESS, NO. STREET

APT.

CITY

PROVINCE

POSTAL CODE

TELEPHONE

MOBILE

E-MAIL

5.2 BANK ACCOUNT INFORMATION

Financial institution

Type of service: personal

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

SIGNATURE OF JOINT ACCOUNT HOLDER (IF APPLICABLE)

FIRST AND LAST NAME (PLEASE PRINT)

FIRST AND LAST NAME (PLEASE PRINT)

DATE (DD/MM/YYYY)

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
 - * 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.
 - 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**
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 SME FORM

7.1 PERSONAL INFORMATION

Have you been covered by the same insurer for a group insurance policy for the past two (2) years?

Yes No If yes, please indicate with which insurer:

COMPANY NAME

If you answered yes, the exclusion for pre-existing conditions does not apply.

7.2 DECLARATION

INITIALS OF PRIMARY INSURED

On the date of signature of the present application, each person to be insured hereby declares that:

1. He/she is not disabled, hospitalized or awaiting hospitalization, has not had any symptoms or conditions for which he/she has yet to consult a doctor, receive treatment or been advised to undergo diagnostic tests or surgery that is yet to take place.
2. In the last three (3) years, he/she has not consulted or been treated for:
 - a) Psychological or psychiatric disorders
 - b) Musculoskeletal disorders (such as: back, neck, knee, shoulders, etc.) causing absence from work for more than ten (10) days or requiring treatment with narcotics such as but not limited to: fentanyl, hydrocodone, hydromorphone (Dilaudid), oxycodone
3. In the last five (5) years, he/she has not had an application for life, monthly indemnity, disability or overhead expenses or a reinstatement that was declined, postponed, withdrawn or accepted with special conditions. (This excludes requests that were postponed pending investigation and for which the results were normal and no treatments or follow-ups were required.)
4. He/she has not been diagnosed or consulted a health professional for any of the following conditions:
 - a) Cancer in the last five (5) years (excluding basal cell carcinoma)
 - b) Chronic obstructive pulmonary disease (excluding asthma),cystic fibrosis
 - c) Acquired immune deficiency syndrome (HIV/AIDS)
 - d) Rheumatoid arthritis, lupus, psoriatic arthritis or chronic ankylosing spondylitis
 - e) Cardiovascular disorders/heart disease
 - f) Diabetes (excluding gestational diabetes)
 - g) Crohn's disease/ulcerative colitis
 - h) Chronic fatigue/fibromyalgia
 - i) Multiple sclerosis, muscular dystrophy or amyotrophic lateral sclerosis
5. In the last ten (10) years, he/she has not been in a drug or alcohol rehabilitation program or been advised to reduce alcohol or drug consumption.

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.

7.3 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

[Signature Line]

CITY

this

[Signature Line]

DAY

day of

[Signature Line]

MONTH, YEAR

[Signature Line]

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

[Signature Line]

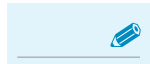
SIGNATURE OF SPOUSE

[Signature Line]

SIGNATURE OF REPRESENTATIVE

7 SME FORM (CONTINUED)

**7.4
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 Yes No Spouse Yes No Children Yes No

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

Primary insured Yes No Spouse Yes No Children 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.

**7.5
SIGNATURE**

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



To be given to the person to be insured

RECEIPT

This amount corresponds to the first premium.

Received the amount of:

AMOUNT


For the person to be insured:

FIRST AND LAST NAME

Date

DD/MM/YYYY

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 SME PLAN
OR
 IF YOU CANNOT SIGN THE SME 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:

<p>Insured 1</p> <input type="text"/> TELEPHONE (HOME)	<p>Insured 2</p> <input type="text"/> TELEPHONE (HOME)
<input type="text"/> TELEPHONE (WORK)	<input type="text"/> TELEPHONE (WORK)
<input type="text"/> MOBILE	<input type="text"/> MOBILE
<p>Preferred language for the call:</p> <input type="text"/> LANGUAGE	<p>Preferred language for the call:</p> <input type="text"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 PM - 2 PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 PM - 4 PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 PM - 6 PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 PM - 9 PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 SME PLAN
 OR
 IF YOU CANNOT SIGN THE SME 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 SME PLAN
 OR
 IF YOU CANNOT SIGN THE SME 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



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

DATE (DD/MM/YYYY)

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



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 SME PLAN
 OR
 IF YOU CANNOT SIGN THE SME 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

Do you already have a Blue Cross policy?
 Yes No
 If yes, please indicate the contract number:

If yes, please complete the table below:

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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	this _____	day of _____
CITY	DAY	MONTH, YEAR
 SIGNATURE OF THE PERSON TO BE INSURED <small>(Policyholder if the person to be insured is under 16 years of age)</small>	 SIGNATURE OF SPOUSE	 SIGNATURE OF REPRESENTATIVE