QUÉBEC BLUE CROSS®

AMI
INSURANCE APPLICATION

Representative number ____ **Contract number** ____ ☐ **New enrollment** ☐ **Change**

1. Personal information

	Last name	First name	Gender	Date of birth (DD / MM / YYYY)
Primary insured			○ M ○ F	
Spouse			○ M ○ F	
Dependent child			○ M ○ F	
Dependent child			○ M ○ F	
Dependent child			○ M ○ F	

Address

No. Street		Apt.
City	Province	Postal code
Telephone - Home	Telephone - Work / Ext.	
E-mail	Language of correspondence ○ French ○ English	

2. Plan selection

- Select your type of coverage: ☐ Family ☐ Individual
- Select your plan. For more protection, you may add the Home Health Care option.

Plan A ☐ Hospitalization and Diagnostic services

Plan B ☐ Hospitalization and Extended health care

Option ☐ Home health care benefit

(This optional benefit is available only when subscribing plan A or B.)

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

	Family coverage		Individual coverage
According to plan selected	$	or	$
Optional benefit, if applicable	$		$
Total	$		$

01QAM0240A (03-17)

QUÉBEC
BLUE CROSS®

3. Method of payment

☐ **Credit card (monthly)**

- **Indicate** the card number and the expiration date.
- **Indicate** the amount of the monthly premium.
- **Do not forget to sign.**

☐

☐ ☐

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Expiration |_|_| MM YY
Card No.

Monthly premium $ ____________

______________________________ ______________
Signature of Cardholder Date

☐ **Cheque (annual)**

- Please enclose a cheque payable to QUÉBEC BLUE CROSS.

☐ **Automatic bank withdrawal (monthly)**

Pre-authorized debit (PAD) agreement

A • PAYOR INFORMATION

FOR ADMINISTRATION ONLY

Contract no. ____________ Insured's name ____________

Last and first names (please print)

Account holder's last name ____________ First name ____________

Joint account holder's last name ____________ First name ____________

Address no. ______ Street ____________ Apt. ______

City ____________ Province ______ Postal code ______

Telephone ______ Cell. ______ E-mail ____________

B • BANK ACCOUNT INFORMATION

TYPE OF SERVICE: PERSONAL

Financial institution ____________

Address no. ______ Street ____________

City ____________ Province ______ Postal Code ______

Institution no. _ _ _ Branch transit no. _ _ _ _ _ Account no. _ _ _ _ _ _ _ _ _ _ _ _

QUÉBEC
BLUE CROSS®

C • AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1 I, the undersigned, hereby authorize Blue Cross Canassurance, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $____________, in 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.

- ☐ **I have attached a cheque in the amount of $_______________representing the 1st premium.**
- ☐ **I have attached a sample cheque. Desired withdrawal date: _______________ (excluding the 29th, 30th and 31st).**

I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing in respect of my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all pre-authorized debits (PADs) 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.cdnpay.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.cdnpay.ca.**

D • SIGNATURE

Signature of account holder	Signature of joint account holder (if applicable)
Name ______________ (please print)	Name ______________ (please print)
Date ______________	Date ______________

4. Signature of the insurance application

Signature of Primary insured	Date
Signature of Spouse	Date

Income Tax Receipt Receipts are mailed before February 28 of the following year.
Please notify Blue Cross of any change of address.

Specific exclusions applicable to some coverages

Hospitalization coverage

1. Fees incurred for cosmetic purposes.
2. Costs incurred while the insured was staying in a long-term care home or in a private convalescent centre either for long-term care or for accommodation only.

Extended Health Care coverage

1. Charges for cosmetic purposes.
2. Fees of a private nurse primarily for custodial care or services rendered for the convenience of the patient.
3. Expenses related to the use of any fertilization technique.

Diagnostic coverage

1. Charges for cosmetic purposes.
2. Fees of a private nurse primarily for custodial care or services rendered for the convenience of the patient.
3. Expenses related to the use of any fertilization technique.

Home Health Care coverage - regular

Specific exclusions

The following exclusions are added to the exclusions applicable to all coverages:

a) Expenses incurred following cosmetic surgery.

b) Expenses incurred following surgery recommended to the insured before this benefit was in force.

c) Expenses incurred after a hospitalization which was planned before the effective date of this benefit.

d) Expenses incurred following a medical consultation planned before this benefit was in force.

e) An accident sustained by the insured while participating in a sport for remuneration or in any kind of motor vehicle competition, race or speed contest.

f) The insured's operation of a motor vehicle or boat with an alcohol level exceeding 80 mg per 100 ml of blood or under the influence of any drug.

g) The insured's participation in a flight or flight attempt in any aircraft in any capacity other than that of a passenger.

Reduction of coverage

Only one medical consultation per calendar year can trigger the reimbursement of eligible expenses, as the case may be.

All expenses incurred following subsequent medical consultations are not eligible for coverage.

Exclusions applicable to all coverages

No insured is entitled to benefits for the expenses specified below, or for a death, injury, disability or illness resulting from the following circumstances:

1. Expenses which are refundable under any other insurance or insured services within the meaning of the law under any federal or provincial legislation or regulations.
2. Abuse of medication or alcohol, or use of narcotics.
3. Suicide, attempted suicide or self-inflicted injury, whatever the state of mind of the insured.
4. Inhalation of gas fumes or ingestion of poison, whether intentional or unintentional.
5. Active participation by the insured in a public confrontation, riot, insurrection, war or act of war, whether declared or not, or any other act of aggression.
6. Expenses incurred outside Canada.
7. Charges for any care, treatment, services or products other than those deemed necessary by the health care professional concerned for the treatment of any injury or illness.
8. Charges for experimental treatments or care and charges resulting from the use of new procedures or treatments not yet in common use.
9. Charges for a detoxification program.
10. Charges that the insured is not required to pay or expenses which would not have been incurred had there been no insurance coverage.

No benefits apply when the insured commits or attempts to commit any criminal act.

Notice regarding personal information

Québec Blue Cross/Canassurance aims to ensure your confidentiality to the greatest possible extent. All personal information received regarding you is kept in a file titled "insurance file." The information we hold is confidential; only employees of the insurer may consult your file, and only as justified as part of their job. As well, unless you object, this information may be used for personalized solicitations by mail or telephone. You may consult your file and correct information as needed by writing to the insurer at: 550 Sherbrooke Street West, Suite B-9, Montréal, QC H3A 3S3.