SASKATCHEWAN BLUE CROSS®

Personal Health Plan Application

516 Second Avenue North PO Box 4030 Saskatoon SK S7K 3T2
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SECTION A

Internal use only

PART 1 — Application Type ☐ New ☐ Add Options ☐ Add Dependent/Spouse

Policy Number (Existing Members)	Broker Number (If Applicable)	Blue Cross or Broker Representative Name (If Applicable)

CONTACT

Mailing Address			City or Town	
Province	Postal Code	Mobile Phone #	Home Phone #	Work Phone #
Email		Marital Status ☐ Single ☐ Married ☐ Common Law ☐ Widowed		

APPLICANT

Last Name	First Name	Birth date (YYYY/MM/DD)	Sex M ☐ F ☐
SK Health Services #	Physician's Name	Height cm ☐ ft ☐	Weight lb ☐ kg ☐

Are you a permanent Saskatchewan resident or in the process of obtaining permanent residency? Yes ☐ No ☐

DEPENDENTS **Dependent is a spouse, unmarried child up to age 18 or up to age 25 if enrolled in full time education, or physically/mentally disabled child unable to leave your care.**

	Spouse	Child	Child	Child
Last Name				
First Name				
Sex (M/F)	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐	M ☐ F ☐
Birth Date (YYYY/MM/DD)				
Height (cm/ft)	cm ☐ ft ☐	cm ☐ ft ☐	cm ☐ ft ☐	cm ☐ ft ☐
Weight (lb/kg)	lb ☐ kg ☐	lb ☐ kg ☐	lb ☐ kg ☐	lb ☐ kg ☐
SK Health Services #				
Physician's Name				
Full Time Student	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Physically or mentally disabled?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If you have more then three dependent children list them in a separate sheet

Critical Illness, Student Accident and Term Life Insurance are underwritten by Blue Cross Life Insurance Company of Canada.

PART 2 — COVERAGE REQUESTED

If Term Life Insurance is selected, complete SECTION B.

Core Health Benefits (required)	■	Critical Illness	☐ $25,000	☐ $10,000		
Prescription Drugs	☐	Student Accident	☐ Double Up	☐ Life Insurance	☐ $10,000	☐ $5,000
Dental	☐	Term Life Insurance	☐ $100,000	☐ $75,000	☐ $50,000	☐ $25,000
Hospital Cash	☐	Child Term Life Insurance	☐ $10,000			
VIP Travel	☐					

OTHER COVERAGE

Have you had or do you currently have Blue Cross coverage or coverage with another Insurer? If yes, provide details below. ☐ Yes ☐ No

Insurance Provider	Policy #	Persons Covered	Coverage
		☐ Applicant ☐ Spouse ☐ Dependent(s)	☐ Health ☐ Drug ☐ Vision ☐ Dental ☐ Travel
		☐ Applicant ☐ Spouse ☐ Dependent(s)	☐ Health ☐ Drug ☐ Vision ☐ Dental ☐ Travel

CONVERSION

Are you or any listed dependents converting from an Employer Benefits Plan? If yes, provide details below. ☐ Yes ☐ No
Option to convert coverage within 60 days of terminating from an employer benefits plan or another Blue Cross plan.

Policy # _____ ID/Certificate # _____ Date Coverage Ends _____

Previous Insurer	Name of Employer	Coverage Included
		☐ Health ☐ Drug ☐ Dental

PART 3 — MEDICAL QUESTIONS

To be completed by applicant and all listed dependents.

1. Have you or any listed dependents, in the last 2 years, consulted or received advice or treatment from any of the following? Check all that apply and provide details below.

☐ Chiropractor ☐ Physiotherapist / Athletic Therapist ☐ Acupuncturist ☐ Massage Therapist
☐ Chiropodist/Podiatrist ☐ Psychologist ☐ Naturopath ☐ Speech Language Pathologist

Name	Type of service	No. of treatments per year	Date first & last treated	Results/Extent of recovery

2. Do you or any listed dependents now use or have the need for any such aids? Check all that apply and provide details below.

☐ Hearing aid ☐ Wheelchair, walker, cane ☐ Hospital beds

☐ Ostomy supplies ☐ Artificial eyes and limbs ☐ Other supplies or equipment not listed

☐ Braces, e.g., splints, exclude dental braces ☐ Orthopaedic shoes, supplies or arch supports

☐ Diabetic supplies and/or equipment ☐ Breathing aids, e.g., oxygen, CPAP, nebulizers or spacers

Name	Medical Supplies/Equipment	Condition

3. Have you or any listed dependents EVER consulted a physician or specialist, been treated for or had any indication of:

☐ Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, or emphysema ☐ AIDS, HIV or other immunological disorder

☐ Multiple Sclerosis ☐ Lupus ☐ Parkinson's ☐ Alzheimer's ☐ Dementia ☐ Scleroderma ☐ ALS

Provide details below.

Name	Condition	Treatment

4. Have you or any listed dependents EVER consulted a physician or specialist, been treated for or had any indication of:

☐ Heart disorders ☐ Stroke ☐ Diabetes/impaired glucose, including diet-controlled ☐ Kidney or liver disease ☐ Cancer or tumour

☐ Arthritis ☐ Crohn's or Colitis ☐ Or any other chronic condition, e.g., chronic pain, chronic fatigue, fibromyalgia, neurological disorders

Provide details below.

Name	Condition	Treatment

5. Do you or any listed dependents have any symptom or complaint regarding your health for which you have not yet consulted a physician? Do you currently have any referral, test or investigation contemplated or pending but not yet completed, or are you expecting to be hospitalized in the next year? If yes, provide details below. ☐ Yes ☐ No

Name	Date	Reason

6. Within the last 2 years, have you or any listed dependents used ambulance services or nursing care? If yes, provide details below. ☐ Yes ☐ No

Name	Date	Reason

7. Have any of your parents or siblings, before attaining age 60, ever had cancer, heart or kidney disease, mental or nervous disorder, or any inheritable disorder? (e.g. Huntington's chorea, polycystic kidney disease etc.) If yes, provide details below. ☐ Yes ☐ No

Family member *(mother, father, brother, sister)*	Age at onset of condition	Name of condition (type of cancer, heart or kidney disease, etc.)

PART 4 — DETAILED MEDICAL QUESTIONS Complete the following section if you answered Yes to any of the above questions or are applying for Prescription Drugs, Hospital Cash, Critical Illness or Term Life Insurance.

1. Have you or any listed dependents EVER consulted a physician or specialist, been treated for or had any indication of:

☐ Chest pain, circulatory trouble, elevated cholesterol ☐ High blood pressure, blood disorder ☐ Alcohol or drug abuse

☐ Headaches/migraines, seizures, paralysis ☐ Bone or joint disorder ☐ Attention Deficit Disorder

☐ Skin disease or disorder, e.g., acne, eczema, psoriasis ☐ Disease or disorder of the reproductive system or infertility, e.g., polycystic ovarian syndrome

☐ Recurrent infections, e.g., bladder, sinus, herpes/cold sores ☐ Respiratory or lung disorder, e.g., asthma

☐ Mental, nervous or emotional disorder, e.g., depression, anxiety, sleep disorders

☐ Stomach, digestive, intestinal, or bladder disorder, e.g., ulcers, IBS, or bowel disorder, GERD or reflux

Provide details below.

Name	Condition	Treatment

2. In the last 6 months, have you or any listed dependents been prescribed any prescription medication or have a prescription for which refills are currently authorized, e.g. oral medication, serum, injection, drops, creams and suppository forms? If yes, provide details below. ☐ Yes ☐ No

Name	Reason	Prescription Name	Strength	Quantity	Refills per year

3. Do you or any listed dependents have a physical impairment, disease or disorder not previously stated, e.g., hearing, vision disorders? If yes, provide details below. ☐ Yes ☐ No

Name	Condition	Treatment

4. In the last 3 years, have you or any listed dependents been hospitalized? If yes, provide details below. ☐ Yes ☐ No

Name	Date	Reason

SECTION B

Complete this section if applying for Term Life Insurance.

PART 1 — PERSONS COVERED

Who do you want to insure? List names below.

_____

PART 2 — REPLACEMENT

Is this policy intended to replace or change an individual life insurance policy? ☐ Yes ☐ No

Note: The insurer has the right to decline an application that indicates replacement is intended.

PART 3 — BENEFICIARY

Life Insured Name	Beneficiary Name	Relationship

Unless otherwise indicated, the beneficiary shall be the applicant, if living; otherwise, the spouse, if any and if living; otherwise, the estate of the life insured.

PART 4 — MEDICAL QUESTIONS

1. Have you or any listed dependents used nicotine or used any smoking cessation products in any form (including e-cigarettes) in the past 12 months?
   If yes, list names below. ☐ Yes ☐ No

   _____

2. Within the past 5 years, have you or any listed dependents consulted a physician, had an x-ray, electrocardiogram or other medical test performed, excluding regular annual checkups, common cold, pregnancy, minor fractures or lacerations? If yes, provide details below. ☐ Yes ☐ No

Name	Treatment	Results

3. During the past 3 years, have you or any listed dependents had your driver's licence suspended or revoked, or been convicted of any of the following:
   3 or more driving violations ☐ Yes ☐ No
   Refusing to take a breathalyzer test ☐ Yes ☐ No
   Driving while impaired? ☐ Yes ☐ No
   If yes, provide details below.

Name	Details

MEDICAL INFORMATION BUREAU NOTICE (detach and retain)

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or its reinsurer may, however, make a brief report thereon to MIB, Inc. ("MIB", formerly Medical Information Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health coverage, or a claim for benefits is submitted to such company, MIB will, on request, supply such company with the information it may have in its files. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's files, you may contact MIB and seek a correction. Additional consumer information regarding MIB is available at www.mib.com.

MIB Information Office
330 University Avenue
Suite 501
Toronto, Ontario, Canada M5G 1R7
Telephone 416.597.0590

Blue Cross Life Insurance company of Canada or its reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AGREEMENT AND CONSENT

By submitting this Application to Saskatchewan Blue Cross, I acknowledge and/or consent to the following:

I declare that the answers to the above questions are complete and accurate and form part of an application for coverage with Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada. This information pertaining to myself and others listed on the application (including spouse/partner, overage (adult) dependents and underage dependents), I understand that any injury that occurred on or before the date of this application or any sickness, the signs of which appeared on or before the date of this application, will not be covered unless fully disclosed on this application. The discovery of facts known by me or my eligible dependents but not stated in this application could result in the cancellation or modification of coverage or the denial of a claim. All information provided herein and collected in the future as part of the application process will be used to determine eligibility for coverage and will be kept confidential and secure.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, and/or its authorized agents/brokers, representatives, licenced physicians and/or any other healthcare professionals or institutions, health and life insurers, MIB, Inc., government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1-800-USEBLUE®.

I acknowledge that this application is subject to approval by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada and is not a contractual obligation. No insurance will take effect unless and until a policy is issued.

I confirm that I have read and understood the entire Application and certify that all questions are answered fully and completely for myself, spouse or dependent if listed, and that the information provided is with each individual's knowledge and consent.

Signature of Applicant _____ Signature of Spouse (if applicable) _____

Date _____

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws.