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/Partner

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

APPLICANT INFORMATION

Mailing Address			City or Town
Province	Postal Code	Email Address	
Mobile Phone #	Home Phone #	Work Phone #	
Last Name	First Name	Birth date (YYYY/MM/DD)	Sex*: Male, Female, Intersex, Undisclosed M☐ F☐ I☐ U☐
I confirm all applicants have provincial health coverage and a Saskatchewan Health Care Card, or have applied for a Saskatchewan Health Care Card. ☐ Yes ☐ No	Physician Name	Height cm☐ ft☐	Weight kg☐ lb☐

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.**

	Partner	Child	Child	Child
Last Name				
First Name				
Sex*: (M/F/I/U)	M☐ F☐ I☐ U☐	M☐ F☐ I☐ U☐	M☐ F☐ I☐ U☐	M☐ F☐ I☐ U☐
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☐
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 than three dependent children, please list them on a separate sheet.

***Sex: Male/Female/Intersex/Undisclosed** - Why do we ask? Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize your sex may differ from your gender identity.

Student Accident Insurance is issued by Blue Cross Life Insurance Company of Canada.

PART 2 — COVERAGE REQUESTED

Core Health Benefits (required) ■

Prescription Drugs ☐ Dental ☐ Hospital Cash ☐ VIP Travel ☐

Student Accident ☐ Student Accident Options:

☐ Double Up

☐ Life Insurance:

Amount : ☐ $10,000 ☐ $5,000

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 ☐ Partner ☐ Dependent(s)	☐ Health ☐ Drug ☐ Vision ☐ Dental ☐ Travel
		☐ Applicant ☐ Partner ☐ 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/Counsellor/Social Worker ☐ 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
- ☐ Ostomy supplies
- ☐ Braces, e.g., splints, exclude dental braces
- ☐ Diabetic supplies and/or equipment
- ☐ Wheelchair, walker, cane
- ☐ Artificial eyes and limbs
- ☐ Orthopaedic shoes, supplies or arch supports
- ☐ Breathing aids, e.g., oxygen, CPAP, nebulizers or spacers
- ☐ Hospital beds
- ☐ Other supplies or equipment not listed

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	Date of Diagnosis
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago

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
- ☐ Any other chronic condition, e.g., chronic pain, chronic fatigue, fibromyalgia, neurological disorders

Provide details below.

Name	Condition	Treatment	Date of Diagnosis
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago

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

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
☐ Chest pain, circulatory trouble, elevated cholesterol
☐ 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	Date of Diagnosis
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago

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

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	Date of Diagnosis
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago
			☐ Less than 2 yrs ago ☐ More than 2 yrs ago

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

Name	Date	Reason

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 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, 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 1.800.667.6853.

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 Partner (if applicable) _____

Date _____

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