SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

PERSONAL HEALTH PLAN APPLICATION

Part 1 — Application Type ☐ New ☐ Add Options ☐ Add Dependent / Partner

Policy Number (Existing members only)	Broker Number (If applicable)	Blue Cross Representative or Advisor Name (If applicable)

APPLICANT CONTACT INFORMATION

First Name | Last Name

Address | City/Town | Province | Postal Code

Primary Phone Number | Secondary Phone Number (If applicable) | Email Address

APPLICANT DETAILS

Date of Birth (YYYY-MM-DD) | Sex* (M/F/I/U)

Height (Specify cm or ft/in) | Weight (Specify kg or lb) | Primary Physician's Name

☐ I confirm all applicants have provincial health coverage and a Saskatchewan Health Card, or have applied for a Saskatchewan Health Card.

***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.

DEPENDENT(S)

A **dependent** is a partner, an unmarried child up to age 18 or up to age 25 if enrolled in full-time education, or a child who is physically or mentally incapable of self-support and unable to leave the care of the policyholder.

PARTNER DETAILS (IF APPLICABLE)

First Name | Last Name

Date of Birth (YYYY-MM-DD) | Sex (M/F/I/U)

Height (Specify cm or ft/in) | Weight (Specify kg or lb) | Primary Physician's Name

DEPENDENT 1 DETAILS (IF APPLICABLE)

First Name | Last Name

Date of Birth (YYYY-MM-DD) | Sex (M/F/I/U)

Height (Specify cm or ft/in) | Weight (Specify kg or lb) | Primary Physician's Name

Full-time student? ☐ | Physically or mentally incapacitated? ☐

DEPENDENT 2 DETAILS (IF APPLICABLE)

First Name | Last Name

Date of Birth (YYYY-MM-DD) | Sex (M/F/I/U)

Height (Specify cm or ft/in) | Weight (Specify kg or lb) | Primary Physician's Name

Full-time student? ☐ | Physically or mentally incapacitated? ☐

DEPENDENT 3 DETAILS (IF APPLICABLE)

First Name | Last Name

Date of Birth (YYYY-MM-DD) | Sex (M/F/I/U)

Height (Specify cm or ft/in) | Weight (Specify kg or lb) | Primary Physician's Name

Full-time student? ☐ | Physically or mentally incapacitated? ☐

IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE PRINT A SECOND COPY OR WRITE ON THE BACK OF THIS FORM.

Part 2A — Personal Health Plan Eligibility

1. a) Have you lost coverage through a group benefits plan or through a personal health plan from another Blue Cross within the last 90 days? Yes ☐ No ☐

*If **yes,** please provide the coverage end date (YYYY-MM-DD):* _____

b) *If **yes,** are you age 50 or older and did you leave your plan as a result of entering retirement?* Yes ☐ No ☐

If you answered:

- **No to a)** — you are eligible for the Blue Choice® or Guaranteed Acceptance plans
- **Yes to a) only** — you are eligible for the Conversion, Blue Choice® or Guaranteed Acceptance plans
- **Yes to a) and b)** — you are eligible for the Retiree, Conversion, Blue Choice® or Guaranteed Acceptance plans

Part 2B — Plan Selection (Please select one of the following plans)

Blue Choice®	Conversion	Guaranteed Acceptance	Retiree
☐	☐	☐	☐

Part 2C — Coverage Selection (Please check off coverage options for the plan selected above)

Plan	Core Coverage (Required — included in each plan)	Additional Coverage Options
Blue Choice®	☐ Core Health	☐ Prescription Drugs ☐ Dental ☐ VIP Travel ☐ Hospital Cash
Conversion	☐ Core Health	☐ Prescription Drugs ☐ Dental ☐ VIP Travel
Guaranteed Acceptance	☐ Core Health ☐ Prescription Drugs ☐ Dental ☐ VIP Travel	
Retiree (Select a coverage level for Core Health, Prescription Drugs and, if applicable, Dental)	☐ Core Health with Embedded VIP Travel ☐ Basic ☐ Classic ☐ Enhanced ☐ Prescription Drugs ☐ Basic ☐ Classic ☐ Enhanced	☐ Dental ☐ Basic ☐ Classic ☐ Enhanced

Note: This application is not a policy, nor a complete description of all benefits.

Part 3 — Coordination of Benefits (COB)

- **If any individuals on this application have other health and dental coverage through other insurance plans,** please provide the details of each below
- **If there are additional plans to coordinate,** please print and complete another copy of this page and submit it with this application

PLAN 1 DETAILS

Policyholder Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

☐ Group Plan (e.g., employer plan, group-based retirement plan) ☐ Student Plan (e.g., unversity/college plan)
☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

☐ Ambulance ☐ Health Spending Account ☐ Travel
☐ Dental ☐ Hospital ☐ Vision – Eye Exams
☐ Extended Health Benefits ☐ Prescription Drugs ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
*If **yes,** please specify below:*

Members covered on this other plan (please fill out table):

Plan 1	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

PLAN 2 DETAILS

Policyholder Full Name: _____ Name of Insurance Carrier: _____

Type of coverage:

☐ Group Plan (e.g., employer plan, group-based retirement plan) ☐ Student Plan (e.g., unversity/college plan)
☐ Individual Plan (e.g., personal plan, personal retirement plan)

Benefits covered (check all that apply):

☐ Ambulance ☐ Health Spending Account ☐ Travel
☐ Dental ☐ Hospital ☐ Vision – Eye Exams
☐ Extended Health Benefits ☐ Prescription Drugs ☐ Vision – Prescription Eyewear

Are there any benefits <u>not</u> covered by this other plan (e.g., massage therapy, orthodontics, etc.)?
*If **yes,** please specify below:*

Members covered on this other plan (please fill out table):

Plan 2	Full Name (List all covered members)	Date of Birth (YYYY-MM-DD)	Effective Date (YYYY-MM-DD)	Termination Date (If applicable; YYYY-MM-DD)
Policyholder				
Partner/Spouse				
Dependent				
Dependent				
Dependent				

Part 4 — Medical Questionnaire and History

Part 4 is required to complete only if:

- You're applying for a Blue Choice® plan; *or*
- You're adding a dependent/partner to a Conversion plan after 60 days.

Otherwise, please skip to Part 5 — Acknowledgment and Consent on the last page of this application.

MEDICAL INFORMATION

Most personal insurance plans require underwriting. We look at all the information you provide us about your health and we make you an offer based on that. We need an accurate and complete medical history for all individuals listed on this application to underwrite your plan properly. This means that any medical condition, injury or sickness (the signs of which first appeared before the date of application) must be fully disclosed.

HAS ANY INDIVIDUAL LISTED ON THE APPLICATION EVER CONSULTED A PHYSICIAN OR MEDICAL PRACTITIONER ON, BEEN TREATED FOR, OR HAD ANY INDICATION OF THE FOLLOWING:

1. Psychologist/Psychiatrist/Counsellor/Social Worker Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

2. Medical Supplies and Equipment
(Braces, walking aids, breathing aids, diabetic supplies or equipment, ostomy supplies, compression/embolic stockings, etc.) Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Type of Supplies or Equipment	Current Status

3. Any Chronic Disease
(Chronic obstructive pulmonary disease [COPD], chronic bronchitis, emphysema, multiple sclerosis, HIV/AIDS, any immunological disorder, lupus, Parkinson's, Alzheimer's/dementia, scleroderma or ALS, etc.) Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

4. Alcohol and/or Drug Abuse
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

5. Bone, Joint or Musculoskeletal Disorder (Gout, low bone density, fibromyalgia, arthritis, ankylosing spondylitis, other)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

6. Cancer or Tumour
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

7. Chest Pain or Heart, Circulatory or Blood Disorder
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

8. Diabetes or Impaired Glucose (Including diet-controlled or gestational diabetes)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

9. High Blood Pressure
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

10. Elevated Cholesterol
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

11. Recurrent Infections (Bladder, sinus, herpes/cold sores, shingles, etc.)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

12. Skin Disorder (Psoriasis, acne, eczema, etc.)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

13. Chronic Headaches, Migraines, or Vertigo/Dizziness
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

14. Neurological Disorder (Seizures/epilepsy, stroke/TIA, paralysis, diabetic neuropathy, cerebral palsy, etc.)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

15. Gastrointestinal Disorder (Ulcers, GERD, Crohn's, colitis, IBS, celiac, pancreatitis, etc.)
*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

16. Kidney or Urinary/Bladder Disorder (Enlarged prostate, overactive bladder, kidney stones, urinary tract infections, IgA nephropathy, etc.) Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

17. Liver Disorder (Hepatitis, cirrhosis, fatty liver, etc.) Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

18. Reproductive or Hormonal Disorder (PCOS, endometriosis, thyroid or pituitary conditions, cysts/fibroids, etc.) Yes ☐ No ☐
*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

19. Mental Health, Behavioural or Sleep Disorder (ADHD/ADD, depression, anxiety, eating disorder, insomnia, etc.)

Yes ☐ No ☐

*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

20. Respiratory/Lung Disorder, Sleep Apnea or Allergies

Yes ☐ No ☐

*If **yes,** please provide the following:*

Applicant/Dependent Name	Reason	Date of Last Symptom or Treatment	Current Status

MEDICATION DETAILS

21. Within the last six months, has any individual listed on this application been prescribed any prescription medication or have a prescription for which refills are currently authorized?

Yes ☐ No ☐

*If **yes,** please provide the following:*

Applicant/Dependent Name	Drug Name and Dose	Reason for Taking	Number of Refills Per Year	Start Date	End Date (Or Ongoing)

ADDITIONAL MEDICAL HISTORY

22. Within the last two years, has any individual listed on this application used ambulance services?

*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Details

23. Within the last two years, has any individual listed on this application been hospitalized?

*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Details

24. Does any individual listed on this application have an outstanding medical referral, test, follow up or investigation pending or have any undiagnosed signs and/or symptoms for which medical consultation is contemplated or expecting to be hospitalized in the next year?

*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Details

25. Does any individual listed on this application have a physical impairment, disease or disorder or any other chronic condition not previously stated? (e.g., Chronic pain, chronic fatigue, etc.)

*If **yes,** please provide the following:*

Yes ☐ No ☐

Applicant/Dependent Name	Details

Part 5 — Acknowledgment 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 pertains to myself and others listed on the application (including partner, overage (adult) dependents and underage dependents). 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, Blue Cross Life Insurance Company of Canada and/or its agents, may be collected, used, maintained and disclosed for the purposes of administering the terms of my policy or the group policy of which I am an eligible member, underwriting, adjudicating and paying claims, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross, helping 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, licensed 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. Limited personal information from my application, such as my email address and other contact information, may be securely provided to our marketing partners and advertising platforms to collect analytical data on the effectiveness of our digital ad campaigns and help build lookalike audiences for future campaigns.

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 may revoke my consent for the use of my personal information for the purpose of marketing analytics at any time without affecting my policy coverage. 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 or to revoke my consent, I can visit www.sk.bluecross.ca/legal/privacy 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 understand that a handwritten signature may be required for any and/or all adult family members in place of an electronic signature for claims audit purposes. Failure to provide this may result in the termination of coverage.

Are you the applicant?

☐ **Yes,** I'm applying for myself or my immediate family.

☐ **No,** I'm completing the application on behalf of the applicant (e.g., advisor, extended family member).

Your Name (First and last): _____

Primary Phone Number: _____

Relationship to the Applicant: _____

Applicant/Authorized Officer Signature	Applicant/Authorized Officer Name (Print)	Date (YYYY-MM-DD)
Partner Signature (If applicable)	Partner Name (Print, if applicable)	Date (YYYY-MM-DD)