INSTRUCTIONS:

1. Please complete all parts of the application, including all questions and details.
2. Missing information will delay the processing of your application.
3. Remember to sign and date your application.
4. The first premium will be deducted upon receipt of the application.
5. Please ensure you attach a signed illustration to the application.

ONTARIO BLUE CROSS®

Blue Vision Association Plan Application Form

ASSOCIATION PLAN | **Health and Dental**

PLEASE NOTE: YOU MUST HAVE A VALID OHIP CARD TO APPLY.

PROVINCIAL HEALTH COVERAGE - Please initial beside response

Important: Please note you must have a valid OHIP Card to apply for coverage. Eligibility for this contract is extended only to residents of Ontario who hold a valid Ontario Health Insurance Plan Card; no other person may be an insured hereunder, even if premium has been accepted by Ontario Blue Cross.

Do you and your spouse and/or dependants have valid OHIP Cards? ☐ Yes _____Initials ☐ No_____Initials

Benefits of the Association Plan are underwritten by Canassurance Hospital Service Association and/or Canassurance Insurance Company hereinafter called Ontario Blue Cross.

1. COVERAGE SELECTION

PLEASE MAKE SELECTIONS FOR A, B, C & D

A) Choose the type of protection:	☐ Single	☐ Couple	☐ Family	☐ Single Parent
B) Select coverage:	☐ EHC Regular	☐ EHC Enhanced	☐ Catastrophe Coverage	
Prescription drugs:	☐ Basic ($1,500)		☐ Deluxe ($10,000)	
C) Add dental option:	☐ Basic Dental		☐ Enhanced Dental	
D) Add Express Plan benefits:	☐ Accidental Loss of Use		☐ Accidental Death	
☐ Critical Illness	☐ Accidental Fracture		☐ Post-accident Adaptations	
☐ Monthly Indemnity	☐ Medical Expenses Due to Accident		☐ Basic Travel	☐ Deluxe Travel

2. PERSONAL INFORMATION

APPLICANT

Last Name				Language ☐ English ☐ French	Sex ☐ M ☐ F	☐ Non-smoker ☐ Smoker
First Name						
Date of Birth	Day	Month	Year	Age		
Address	No.	Street			Apt.	
	City			Province	Postal Code	

Telephone No. ☐ Home ☐ Cell. ☐ Work Telephone No. ☐ Home ☐ Cell. ☐ Work

E-mail Address

Should we require further information to process your application, may we phone you during business hours? ☐ Yes ☐ No Most convenient time:_____

Please complete information for each person to be covered. Minimum applicant age is 16 years of age.

					Date of Birth				Height	Weight
	Last Name	First Name	Relationship	Sex	Day	Month	Year	Age	(in./cm)	(lb/kg)
Applicant				☐M ☐F						
Spouse				☐M ☐F						
Dependants				☐M ☐F						
				☐M ☐F						
				☐M ☐F						
				☐M ☐F						

3. ASSOCIATION FORM

A) DECLARATION

NOTE

If the persons to be insured have completed a health statement and have been accepted by Ontario Blue Cross, the exclusion for pre-existing conditions above mentioned will not apply to those mentioned in the health statement.

1. Each person to be insured hereby declares the following:

a) Never has had an application or a reinstatement of insurance that was declined, postponed, withdrawn or accepted with special conditions.

b) That he/she has not been diagnosed or has consulted a health professional for one of the following conditions:

- Musculoskeletal Disorder (that caused the applicant to miss work in the last twelve (12) months) or that is requiring ongoing treatment by narcotics (such as: fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, dilaudid).
- Spine Diseases (causing the applicant to miss more than five (5) business days of work in the last twenty-four (24) months)
- Alzheimer's Disease or dementia
- Thoracic or Abdominal Aortic Aneurysm
- Rheumatoid Arthritis or Psoriatic Arthritis
- Liver Cirrhosis
- Inflammatory Intestinal Disease (causing the applicant to miss more than fifteen (15) business days of work in the last twenty-four (24) months)
- Chronic Obstructive Pulmonary Disease
- Cystic Fibrosis
- Peripheral Vascular Disease
- Chronic Pancreatitis
- Parkinson's Disease
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis
- Acquired Immune Deficiency Syndrome (AIDS), HIV
- Myeloproliferative Syndrome
- Organ Transplants
- Breast Cancer
- Diabetes Mellitus (type 1 or 2)
- Hepatitis (B or C)

3. ASSOCIATION FORM (CONTINUED)

NOTE

No representative is authorized to establish or modify an Ontario Blue Cross contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Ontario Blue Cross.

- Cancer (diagnosed in the past 5 years, excluding basal cell carcinoma of the skin and cervical cancer in situ)
- Epilepsy (Grand mal, attack within 6 months)
- Chronic Fatigue Syndrome
- Fibromyalgia
- Chronic Renal Failure or Chronic Renal Disease
- Transient Ischemic Attack/Stroke
- Leukemia
- Lymphoma
- Systemic Lupus Erythematosus
- Heart Diseases (Angina Pectoris, Myocardial Infarction, Coronary Artery Bypass, Coronary Artery Angioplasty, Acute Coronary Syndrome) or Valvular Heart Disease (Including all Valvular Heart Disease)
- In the last 5 years you have not been in a drug rehabilitation program or been advised to do so or consumed: methamphetamine, cocaine, steroids or narcotics.
- Nervous disorders: Currently being treated or have been treated in the last 24 months for: depression, burnout, anxiety, chronic fatigue, attempted suicide, ADD/ADHD, eating disorders, delayed mental development, Schizophrenia or sleep disorder (including insomnia).
- In the last 5 years you have never received or been advised to undergo treatments or counselling for alcohol abuse or been charged with more than one DUI.
- In the last 5 years, you have never been charged, convicted or are awaiting trial for a criminal offence (excluding DUI).

c) Not being hospitalized, awaiting hospitalization or disabled on the date of the signature of the present application;

d) Have no pending medical examinations (other than for a common cold or annual physical examinations including routine blood work) or no current symptoms for which the client has not yet consulted a health care professional.

2. Each person to be insured acknowledges the following:

Exclusion for pre-existing conditions (applicable for the Term life 65, Life hybrid, Monthly indemnity due to accident and illness, Disability due to accident and illness, Disability hybrid and the Overhead expenses benefits).

With regard to any amount granted with the Association Form declaration, no benefit will be payable for a claim relating to an event occurring within twelve (12) months following the effective date of coverage if the claim is a result of a condition for which the insured consulted a physician, took medication, received medical treatments or was prescribed diagnostic tests in the twelve (12) month period preceding the effective date of coverage.

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

_____ SIGNATURE OF PRIMARY INSURED

_____ SIGNATURE OF SPOUSE

_____ SIGNATURE OF REPRESENTATIVE

B) SHORTENED HEALTH STATEMENT

To be completed for **Deluxe drug coverage** only.

	Primary Insured	Spouse	Children
1. Are the persons to be insured currently taking any medication, or have they taken any medication in the last twelve (12) months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have the persons to be insured ever been informed by a doctor that they are suffering from a chronic disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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 occurence	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 might otherwise be valid.

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

_____ SIGNATURE OF PRIMARY INSURED

_____ SIGNATURE OF SPOUSE

_____ SIGNATURE OF REPRESENTATIVE

4. EXPRESS PLAN DECLARATION

A) DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT

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

   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 have 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, heroin, 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.

Signed in _____ (CITY) this _____ (DAY) day of _____ (MONTH, YEAR)

_____ SIGNATURE OF THE PERSON TO BE INSURED

_____ SIGNATURE OF REPRESENTATIVE

B) DECLARATION FOR MONTHLY INDEMNITY DUE TO ILLNESS EXPRESS (if applicable)

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)

C) DECLARATION FOR ALL EXPRESS PLAN BENEFITS

NOTE

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.

NOTE

No representative is authorized to establish or modify an Ontario Blue Cross contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Ontario Blue Cross.

1. On the date of signing this application, each person to be insured declares the following:
   a) He/she is not disabled or receiving disability benefits.
   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 he/she holds a valid health card from their provincial health plan as defined by the health and hospital insurance legislation in his/her province of residence.
3. 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.
4. Each person to be insured, hereby confirms that he/she has been informed of all statements recorded in this application.
5. The Primary Insured asks that Ontario Blue Cross issue a contract as specified herein.
6. This declaration offers no guarantee of insurance.
7. The Primary Insured acknowledges receipt of the "Notice regarding personal information" and "Notice regarding the Medical Information Bureau and exchange of information".

Signed in _____ (CITY) this _____ (DAY) day of _____ (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

5. PAYMENT - please select only one method of payment (A, B or C). The first premium will be withdrawn on receipt of your application.

A. ☐ CREDIT CARD PAYMENT	☐ MONTHLY ☐ ANNUAL	☐ Amex ☐ Master Card ☐ VISA	Signature of Cardholder:
	Card Number		Expiry Date: M Y
B. ☐ ANNUAL CHEQUE	Please attach a cheque payable to **ONTARIO BLUE CROSS**. (monthly rate x 12)		
C. ☐ MONTHLY AUTOMATIC BANK WITHDRAWALS	Please complete sections 3 and 4 of the pre-authorized debit (PAD) agreement and attach a void cheque.		

Following approval of your application, subsequent payments will be withdrawn on the policy effective date each month following, unless an alternate date has been selected for subsequent payments, for automatic bank withdrawals only.

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Sections 1 and 2 are to be completed if you are not attaching a void cheque.

FOR ADMINISTRATION ONLY

Contract no. _____ Insured's name_____

1. PAYOR INFORMATION (PLEASE PRINT)

Last and first names of depositors

Account holder name _____ First name _____

Joint account holder name _____ First name _____

Address _____ Street _____ Apt _____

City _____ Province _____ Postal code _____-_____

Telephone (____) _____ - _____ Cell (____) _____ - _____ E-mail _____

TYPE OF SERVICE: PERSONAL

2. BANK ACCOUNT INFORMATION

Financial institution _____

Address _____ Street _____

City _____ Province _____ Postal code _____-_____

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

3. AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1. I, the undersigned, hereby authorize Ontario Blue Cross, 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 Ontario Blue Cross without giving me prior notice.

   Desired withdrawal date: _____ **(excluding the 29th, 30th and 31st).** I have attached a sample cheque ☐

   I authorize Ontario Blue Cross 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 (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 Ontario Blue Cross 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, Ontario Blue Cross 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 Ontario Blue Cross 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 1 866 722-3444. **I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, Ontario Blue Cross 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 Ontario Blue Cross 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 Ontario Blue Cross 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.

4. SIGNATURE

SIGNATURE OF THE ACCOUNT HOLDER	SIGNATURE OF JOINT ACCOUNT HOLDER (If applicable)
NAME	NAME
DATED (DAY/MONTH/YEAR)	DATED (DAY/MONTH/YEAR)

6. IMPORTANT INFORMATION, AGREEMENT, CONSENT & PRIVACY

FAILURE TO COMPLETE THIS APPLICATION IN ITS ENTIRETY WILL RESULT IN DELAYS.

Contract Effective Date: The contract will become effective on the date of approval by Ontario Blue Cross provided the first premium is paid in full and that no change occured in the insurability of the person(s) to be insured since the signature of the application. **10-day Right to Examine:** You have 10 days from the effective date of your policy to examine and return it for refund of monies paid, if you are not entirely satisfied.

In applying for this coverage, I understand that Ontario Blue Cross needs to know the complete medical history of myself and of any family members. I have read over the application and certify that all questions are answered fully and correctly. I understand and agree that any injury that occurred on or before the date of this application or any sickness which appeared on or before the date of this application must be fully disclosed on this application and may not be covered. I understand and agree that it is my obligation to inform Ontario Blue Cross of any change in the health of myself and of any family members to be covered due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.

The discovery of facts known by me or by my covered dependants but not disclosed to Ontario Blue Cross could result in the denial of a claim and the cancellation or modification of the policy. I agree that this application, any supplemental information as required by Ontario Blue Cross, and the policy shall constitute the entire contract. **NOTICE REGARDING PERSONAL INFORMATION:** I hereby authorize Canassurance Hospital Service Association (Ontario Blue Cross) and its subsidiaries[1], to collect, use and disclose any personal information regarding myself and/or my dependant children from and to the following individuals and organizations: any licensed medical practitioner or licensed health professional, hospital, clinic or medical related facility, any other insurance company, including any reinsurance company, or any other person or organization with information relevant to my claim or coverage, and any other person or organization that provides information services or insurance services to, or that acts as an insurance intermediary for Ontario Blue Cross. Ontario Blue Cross aims to ensure the greatest confidentiality possible. All of your personal information is kept in a file titled "Insurance File". The information held by Ontario Blue Cross is confidential; only an employee of Ontario Blue Cross may consult your file, and only if justified as part of his or her job. As well, unless you object, this information may be used for personal solicitations by mail or by telephone. You may consult your file and correct the information as needed by writing to Ontario Blue Cross at: 185 The West Mall, Suite 610, Etobicoke, ON, M9C 5P1.

I agree that no coverage is in effect unless and until my application is **approved** by Ontario Blue Cross.

This consent is valid for the length of time necessary for Ontario Blue Cross to achieve the purposes mentioned in the Notice regarding personal information. I understand that I may withdraw this consent at any time by giving Ontario Blue Cross written notice of withdrawal. I also understand that withdrawal of my consent could result in Ontario Blue Cross being unable to provide coverage or pay claims. A photocopy of this authorization is as valid as the original. For further details, please visit our Website at **www.on.bluecross.ca** or contact us by phone.

DATED (DAY/MONTH/YEAR)	SIGNATURE OF APPLICANT	SIGNATURE OF SPOUSE

For Agent Use Only

Agent Name:	Agent #:	%:	Telephone:	Fax:	Agent Signature:
Brian D. McCreery	16485	100	416-862-8172	416-862-2498	
Other Agent Name (if applicable):	Agent #:	%:	Telephone:	Fax:	Agent Signature:

*No representative is authorized to establish and/or modify an Ontario Blue Cross contract, to determine if a person to be insured constitutes as an acceptable risk or to waive any right or requirement in the name of Canassurance Hospital Service Association and/or Ontario Blue Cross.

For Ontario Blue Cross Use Only

Identification No.	Underwriting Approval
	Signature / Dated(Day/Month/Year)

[1] Canassurance Insurance Company and CanAssistance Inc.