

NAME OF FIRM	REPRESENTATIVE	CONTRACT NO.
	NAME	
	CODE NUMBER	APPLICATION NO. CO

1. PERSONAL INFORMATION

PRIMARY INSURED							
Last name						Language choice	Sex
First name						<input type="checkbox"/> French <input type="checkbox"/> English	<input type="checkbox"/> M <input type="checkbox"/> F
Date of birth	Day	Month	Year	Age	Place of birth		
Address	No.	Street				Apt.	
	City		Province		Postal code		
Telephone	Home ()		Work ()		E-mail		
Civil status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-law marriage						
Name of employer _____ Tel. () _____							
Occupation (specify duties) _____							
Date of hiring _____ E-mail _____							
Annual salary or net annual earnings: (after expenses and before taxes) \$ <input type="text"/>					GLOBAL PLAN or SMEs PLAN only		
Are you: <input type="checkbox"/> an employee <input type="checkbox"/> a company owner <input type="checkbox"/> self-employed					Do you contribute to:		
If you are self-employed since less than one year please indicate the number of years of experiment in the same field _____					Employment Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
					the WSIB? <input type="checkbox"/> Yes <input type="checkbox"/> No		
May we include your name on a Blue Cross solicitation list? <input type="checkbox"/> Yes <input type="checkbox"/> No							

IF YOU HAVE CHOSEN A PROTECTION THAT INCLUDES FAMILY, COUPLE OR SINGLE-PARENT COVERAGE, PLEASE COMPLETE THE SECTION BELOW

SPOUSE				Sex	Date of birth			Age
Last name	First name			<input type="checkbox"/> M <input type="checkbox"/> F	Day	Month	Year	
DEPENDENT CHILD				Sex	Date of birth			Age
Last name	First name	Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	Day	Month	Year	
				<input type="checkbox"/> M <input type="checkbox"/> F				
				<input type="checkbox"/> M <input type="checkbox"/> F				
				<input type="checkbox"/> M <input type="checkbox"/> F				
				<input type="checkbox"/> M <input type="checkbox"/> F				

2. POLICYHOLDER INFORMATION (if different from Primary Insured)

Last name						Language choice	Sex	Date of birth			Age
First name						<input type="checkbox"/> French <input type="checkbox"/> English	<input type="checkbox"/> M <input type="checkbox"/> F	Day	Month	Year	
Address	No.	Street				Apt.					
	City		Province		Postal code						
Telephone	Home ()		Work ()		E-mail						

3. BENEFICIARY

Last name		Relationship	
First name		<input type="checkbox"/> Revocable	<input type="checkbox"/> Irrevocable

4. EXPRESS PLAN

Primary Insured <input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker	Premium	Amount insured	Monthly premium
		\$	\$
Life Express			
	Level		
Accidental death			
	Level		
Accidental loss of use			
	Level		
Life, Accidental death and loss of use - child			
	Level		
Hospital allowance Express			
	Level		
Premium refund upon death - Hospital allowance Express			
	Level		
Critical illness assistance			
	<input type="checkbox"/> Attained age <input type="checkbox"/> Level		
Premium refund at termination date - Critical illness assistance			
	Level		
Accidental fracture			
<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Level	
Post-accident adaptations			
<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Level	
Medical expenses due to accident			
<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Level	
Travel insurance			
<input type="checkbox"/> Basic <input type="checkbox"/> Deluxe	<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Attained age
Home health care			
<input type="checkbox"/> Basic <input type="checkbox"/> Deluxe	<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Attained age
Monthly indemnity due to accident Express			
	Level		
Monthly indemnity due to illness Express			
	Waiting period <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days	Level	
Express Plan health package			
<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple	<input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Attained age	
A - Monthly premium - subtotal			\$

5. GLOBAL PLAN or SMEs PLAN

Occupational categories		Primary Insured <input type="checkbox"/> A <input type="checkbox"/> 2A <input type="checkbox"/> 3A <input type="checkbox"/> 4A <input type="checkbox"/> B <input type="checkbox"/> OO	Premium	Amount insured	Monthly premium
		Primary Insured <input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker		\$	\$
Disability due to accident					
	Waiting period		Benefit period		
Protection 1	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Taxable <input type="checkbox"/> Indexed <input type="checkbox"/> Non taxable <input type="checkbox"/> Unindexed	Level	
Protection 2	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Taxable <input type="checkbox"/> Indexed <input type="checkbox"/> Non taxable <input type="checkbox"/> Unindexed	Level	
Disability due to illness					
	Waiting period		Benefit period		
Protection 1	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Taxable <input type="checkbox"/> Indexed <input type="checkbox"/> Non taxable <input type="checkbox"/> Unindexed	Level premium option <input type="checkbox"/> Yes <input type="checkbox"/> No	
Protection 2	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Taxable <input type="checkbox"/> Indexed <input type="checkbox"/> Non taxable <input type="checkbox"/> Unindexed	Level premium option <input type="checkbox"/> Yes <input type="checkbox"/> No	
Regular occupation - Disability due to accident					
<input type="checkbox"/> 5 years (Available for B, A and 2A only)			Level		
<input type="checkbox"/> to age 65 (Available for B, A, 2A and 3A only)					
Regular occupation - Disability due to illness					
<input type="checkbox"/> 5 years (Available for B, A and 2A only)			See Disability (illness)		
<input type="checkbox"/> to age 65 (Available for B, A, 2A and 3A only)					
Premium refund (65) - Disability due to accident				Level	
Premium refund (65) - Disability due to illness				Level	
Monthly indemnity due to accident					
	Waiting period		Benefit period		
Protection 1	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	Level		
Protection 2	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	Level		
Monthly indemnity due to illness					
	Waiting period		Benefit period		
Protection 1	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 5 years	Level		
Protection 2	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 5 years	Level		
Overhead expenses					
	Waiting period		Benefit period		Level premium option
	<input type="checkbox"/> 30 days <input type="checkbox"/> 30M days	2 years	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospital allowance					
<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple <input type="checkbox"/> Single-parent <input type="checkbox"/> Family			<input type="checkbox"/> Attained age <input type="checkbox"/> Level		
Term life 65			<input type="checkbox"/> Attained age <input type="checkbox"/> Level		
Extended health benefit					
<input type="checkbox"/> Regular coverage	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single-parent	Attained age		
<input type="checkbox"/> Enhanced coverage	<input type="checkbox"/> Couple	<input type="checkbox"/> Family			
<input type="checkbox"/> Catastrophe coverage					
Drug benefit					
<input type="checkbox"/> Basic coverage	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single-parent	<input type="checkbox"/> Attained age		
<input type="checkbox"/> Deluxe coverage	<input type="checkbox"/> Couple	<input type="checkbox"/> Family			
Dental care		<input type="checkbox"/> Primary Insured <input type="checkbox"/> Couple <input type="checkbox"/> Single-parent <input type="checkbox"/> Family	Attained age		
Should the Express Plan benefits be issued on the same date as the Global Plan ones? <input type="checkbox"/> Yes <input type="checkbox"/> No			B - Monthly premium - subtotal		\$
			Total premium A + B		\$
			Benefit fee		\$
			Disability due to accident		\$
			Policy fee		\$
			Total monthly premium		\$
			Annual premium = monthly premium x 12		\$

Please complete the "Health Statement Blue Vision" form or the "SMEs Form" according to the selected plan.

A minimum annual premium of \$100 is required unless the "Critical illness assistance" benefit was selected.

METHOD OF PAYMENT

MONTHLY CREDIT CARD PAYMENT: Amex MasterCard VISA
| | | | | | | | | | | | | | | | | | | | | |

MONTHLY DIRECT DEBIT: Please sign the following authorization and attach a void cheque.
AUTHORIZATION: I authorize the Insurer to make monthly withdrawals from my account, the number of which is shown on the attached void cheque.

Desired date for withdrawing monthly premium (except the 29th, 30th or 31st of the month)

Signature of account holder

ANNUAL CHEQUE: Please attach a cheque payable to ONTARIO BLUE CROSS

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

I hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company to collect, use, disclose any personal information regarding myself and/or my dependent children from and to the following individuals and organizations: any licensed medical practitioner or licensed health professional, hospital, clinic or medical related facility, the Medical Information Bureau (MIB), any other insurance company, including, any reinsurance company, or any other person or organization with information relevant to my claim or coverage, and any person or organization that provides information services or insurance services to, or that acts as an insurance intermediary for Canassurance Hospital Service Association and/or Canassurance Insurance Company.

This consent is valid for the length of time necessary for Canassurance Hospital Service Association and/or Canassurance Insurance Company to achieve the purposes mentioned in the Notice regarding personal information. I understand that I may withdraw this consent at any time by giving Canassurance Hospital Service Association and/or Canassurance Insurance Company written notice of withdrawal. I also understand that withdrawal of my consent could result in Canassurance Hospital Service Association and/or Canassurance Insurance Company inability to provide coverage or pay claims.

A photocopy of this authorization is as valid as the original.

_____ Date

_____ Signature of Primary Insured

_____ Signature of Representative

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

I hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company to collect, use, disclose any personal information regarding myself and/or my dependent children from and to the following individuals and organizations: any licensed medical practitioner or licensed health professional, hospital, clinic or medical related facility, the Medical Information Bureau (MIB), any other insurance company, including, any reinsurance company, or any other person or organization with information relevant to my claim or coverage, and any person or organization that provides information services or insurance services to, or that acts as an insurance intermediary for Canassurance Hospital Service Association and/or Canassurance Insurance Company.

This consent is valid for the length of time necessary for Canassurance Hospital Service Association and/or Canassurance Insurance Company to achieve the purposes mentioned in the Notice regarding personal information. I understand that I may withdraw this consent at any time by giving Canassurance Hospital Service Association and/or Canassurance Insurance Company written notice of withdrawal. I also understand that withdrawal of my consent could result in Canassurance Hospital Service Association and/or Canassurance Insurance Company inability to provide coverage or pay claims.

A photocopy of this authorization is as valid as the original.

_____ Date

_____ Signature of Spouse

_____ Signature of Representative

NOTICE REGARDING PERSONAL INFORMATION

By applying for our insurance product(s), you are consenting to our collecting, using and disclosing your personal information for the purposes of appraising your insurance application, confirming your coverage and/or benefits, processing or paying your claims.

Your insurance file will be maintained on a confidential basis at our offices. Your personal information will only be accessible by our employees and authorized representatives who need access to your file for the purposes set out above.

Upon written notice, you will be entitled to access the personal information contained in your file and, if applicable, request that your file be updated or corrected.

For additional information regarding the manner in which we collect, use, disclose and otherwise manage your personal information, please visit our Web site www.useblue.com or write to us at:

Chief Privacy Officer
Canassurance Hospital Service Association and/or Canassurance Insurance Company
185 The West Mall, Suite 600, Etobicoke, Ontario M9C 5P1
privacyofficer@ont.bluecross.ca

INVESTIGATIVE CONSUMER REPORT AND EXCHANGE OF INFORMATION

Information regarding your insurability will be treated as confidential. The Insurer or the Insurer's reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members, if you apply to another Bureau member company for life or health coverage, the Bureau, on request, will supply such company with the information about you in its files.

All insurers including Canassurance Hospital Service Association and/or Canassurance Insurance Company sometimes write investigative consumer reports in applying standards on processing of applications. The report generally includes information on those to be insured and their lifestyle.

Upon request from you, the Medical Information Bureau will arrange to disclose to you the information in your file, except for medical information, which will be given only to your doctor. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and ask to have it corrected. The address of the Bureau's Information Office is as follows:

MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, SUITE 501, TORONTO, ONTARIO M5G 1R7
TELEPHONE: (416) 597-0590 / FAX: (416) 597-1193

TO BE GIVEN TO THE PRIMARY INSURED

FOR REPRESENTATIVES USE ONLY

AMOUNTS GRANTED WITHOUT A HEALTH STATEMENT (SMEs PLAN)

Is the person to be insured entitled to the amounts granted without a health statement? Yes No If yes, indicate SME name _____

MEDICAL REQUIREMENTS

Types of requirements requested on _____
Date _____ Firm _____

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Paramedical examination | <input type="checkbox"/> H.I.V. urine test | <input type="checkbox"/> ECG | <input type="checkbox"/> Regular investigation |
| <input type="checkbox"/> Medical examination | <input type="checkbox"/> Blood profile | <input type="checkbox"/> ECG at rest | <input type="checkbox"/> Amplified investigation |

® The Blue Cross name and symbol and the Blue Vision name are registered trademarks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans, and are licensed to the Canassurance Hospital Service Association, carrying on business as Ontario Blue Cross. ™ The Ontario Blue Cross name and symbol are trademarks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans, and are licensed to the Canassurance Hospital Service Association, carrying on business as Ontario Blue Cross.

AUTHORIZATION

AUTHORIZATION

**NOTICE REGARDING
PERSONAL INFORMATION**

**INVESTIGATIVE CONSUMER REPORT
AND EXCHANGE OF INFORMATION**

7. EFFECTIVE INSURANCE

Are you already insured under another Blue Cross policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the contract number:					
Do you have any other insurance policies? Life insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Disability <input type="checkbox"/> Yes <input type="checkbox"/> No					
LIFE INSURANCE			DISABILITY INSURANCE		
Company	Amount insured	Company	Monthly benefits	Waiting period	Benefit period

REPLACEMENT
I certify that this insurance application replaces the following policy or policies (specify name of company, coverage and termination date):

I understand that the coverage and/or partial coverage granted by Canassurance Hospital Service Association and/or Canassurance Insurance Company, based on the preceding declarations, shall be null and void if the coverage which is to be replaced is maintained effective. I also understand that the coverage and/or partial coverage granted by Canassurance Hospital Service Association and/or Canassurance Insurance Company shall take effect on the termination date of the coverage replaced.

8. DECLARATIONS

DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT

I, the undersigned, hereby declare that a critical illness contract covering at least 5 illnesses covered by Blue Vision contract and for an amount of insurance of at least \$25 000 has been issued by another insurer for the person to be insured within 60 days preceding the signing of this application.

Name of company issuing the contract	Contract no. and effective date
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Signed in _____ this _____ day of _____

Signature of Primary Insured X Signature of Representative X

Each person to be insured hereby declares that he/she has never consulted a doctor, been hospitalized, taken drugs or received a treatment for any of the following conditions:

<p>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</p> <p>b) Chronic obstructive pulmonary disorders: asthma, emphysema, chronic bronchitis, lung transplant</p>	<p>c) Neurological disorders: stroke, transient cerebral ischemia (TCI)</p> <p>d) Insulin-dependent diabetes: diabetes treated with insulin</p> <p>e) Kidney failure, kidney transplant</p> <p>f) Gastrointestinal disorders: cirrhosis, hepatitis, ulcer, internal bleeding, liver transplant, surgery for bowel obstruction</p> <p>g) Cancer or malignant tumour</p>
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Signed in _____ this _____ day of _____

Signature of Primary Insured X Signature of Representative X

DECLARATION FOR MONTHLY INDEMNITY DUE TO ILLNESS EXPRESS

Each person to be insured hereby declares that he/she has not, for the last 3 years:

- had an insurance application declined, suspended or accepted with special conditions
- been treated or consulted for use of alcohol or drugs
- been hospitalized twice or more (except for pregnancy)
- been treated or taken medication for cancer, tumor, cardiovascular disorders, neurological, psychological, diabetes, kidney failure, high blood pressure superior to 170/100 (maximal indicator exceeds 170 or minimal indicator exceeds 100)

Signed in _____ this _____ day of _____

Signature of Primary Insured X Signature of Representative X

DECLARATION FOR ALL EXPRESS PLAN BENEFITS

Each person to be insured hereby declares the following:

- On the date of signing this application, I am not disabled, not hospitalized or waiting to be hospitalized. I also declare that I do not have cancer and have never had cancer in the past or AIDS or any form of pre-AIDS.

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.

DECLARATION FOR ALL EXPRESS PLAN AND GLOBAL PLAN BENEFITS

- Each person to be insured, hereby declares that he/she is a beneficiary in the meaning of the health and hospital insurance legislation in his/her province of residence.
- 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.
- The Primary Insured asks that Canassurance Hospital Service Association and/or Canassurance Insurance Company issue a contract as specified herein.
- This declaration offers no guarantee of insurance.
- The Primary Insured acknowledges receipt of the "Notice regarding personal information" and "Investigative consumer report and exchange of information."

Signed in _____ this _____ day of _____

X Signature of Primary Insured X Signature of Spouse X Signature of Representative

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