

Instructions:

1. Please print in ink or submit your application on-line at www.useblue.com
2. Complete all unshaded areas of the application, including all questions & details.

3. Missing information will delay the processing of your application.
4. Remember to sign and date your application.
5. Original application is required.



Blue Choice® Health Care Plan Application Form

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

1. COVERAGE SELECTION

PLEASE MAKE SELECTIONS FOR A, B & C

a) Choose the type of Protection:	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Single Parent
b) Select a Plan:	<input type="checkbox"/> Core Health Benefits	<input type="checkbox"/> Hospital Benefits	<input type="checkbox"/> Core Health & Hospital Benefits	
c) Add Options:	<input type="checkbox"/> Drugs	<input type="checkbox"/> Dental	<input type="checkbox"/> No Options	

2. PERSONAL INFORMATION

PRIMARY INSURED

Last Name					Language			Sex	
First Name					<input type="checkbox"/> English <input type="checkbox"/> French			<input type="checkbox"/> M <input type="checkbox"/> F	
Date of Birth	Day	Month	Year	Age					
Address	No.	Street			Province			Apt.	
	City						Postal Code		
Telephone No. (Daytime) • Please specify : <input type="checkbox"/> Home <input type="checkbox"/> Cell. <input type="checkbox"/> Work									
Telephone No. (Evening)					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.

	Last Name	First Name	Relationship	Sex	Date of Birth				Height (in./cm)	Weight (lb/kg)
					Day	Month	Year	Age		
Applicant				<input type="checkbox"/> M <input type="checkbox"/> F						
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F						
Children				<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						

3. MEDICAL INFORMATION – based on your medical history, you may be declined or excluded for specific benefits.

PROVINCIAL HEALTH COVERAGE – Please initial beside response

Do you and your Spouse and/or Dependents have valid OHIP Cards? Yes ____Initials No ____Initials

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.

TO BE COMPLETED BY ALL APPLICANTS:

1. Have you, your spouse or any listed dependents consulted and/or received advice or treatment from a registered specialist or therapist (Chiropractor, Physiotherapist, Psychologist, Masseur etc.) during the past two years, or have you been advised to do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you, your spouse or any listed dependents purchased, during the past two years or plan to purchase orthopaedic shoes, supplies or arch supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you, your spouse or any listed dependent rented/purchased during the past two years or plan to rent/purchase assistive devices (artificial limbs, braces, etc.), medical equipment or supplies (walker, wheelchair, oxygen, CPAP machine, ostomy supplies etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, your spouse or any listed dependent required ambulance services or nursing care during the past two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you, your spouse or any listed dependent consulted a physician or specialist about, been treated for or had any known indication of: heart or circulatory disorder, angina, heart attack, arrhythmia (irregular heartbeat), TIA (mini-stroke) or stroke, insulin dependent diabetes, chronic kidney or liver disease, Chronic Obstructive Pulmonary Disease (COPD) or emphysema, leukemia or cancer (excluding basal cell carcinoma), Multiple Sclerosis, Motor Neurone Disease, Alzheimer's, Parkinson's, senile dementia or any inheritable disorder (such as polycystic kidney disease or Huntington's Chorea)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS BELOW, PROCEED TO THE NEXT PAGE OF THIS APPLICATION AND COMPLETE THE REMAINDER OF THIS SECTION, PROVIDING FULL DETAILS. IF YOU HAVE ANSWERED 'NO' TO ALL OF THE ABOVE QUESTIONS AND ARE **NOT APPLYING FOR HOSPITAL COVERAGE AND/OR PRESCRIPTION DRUG OPTIONS**, PLEASE PROCEED DIRECTLY TO SECTIONS 4 & 5 OF THIS APPLICATION.

Persons Name	Date	Details – If space does not allow for a full description of the details, please use the 'Additional Information' section on the reverse of this application.

7. TO BE COMPLETED WHEN APPLYING FOR HOSPITAL COVERAGE OR PRESCRIPTION DRUG OPTION, OR IF ANY QUESTIONS ABOVE HAVE BEEN ANSWERED 'YES'.

APPLICANT	Name and address of personal physician:	Date Last Consulted (DD/MM/YY):
	Reason (if for check-up, what problems/symptoms did you have)?	
	Findings and/or treatment:	
SPOUSE	Name and address of personal physician:	Date Last Consulted (DD/MM/YY):
	Reason (if for check-up, what problems/symptoms did you have)?	
	Findings and/or treatment:	

TO BE COMPLETED WHEN APPLYING FOR HOSPITAL COVERAGE OR PRESCRIPTION DRUG OPTION, OR IF ANY QUESTIONS ABOVE HAVE BEEN ANSWERED 'YES'.

8. Are you, your spouse or any listed dependent currently taking any prescription medication, have a prescription for which refills are authorized, or have a prescription that has not been filled as of yet? Yes No

Persons Name	Prescription Name	Strength	Daily Qty.	Reason	Cost per Presc.	# of Refills/Yr.

PLEASE SELECT EITHER YES OR NO FOR ALL QUESTIONS

9. Have you, your spouse or any listed dependent EVER consulted a physician or specialist, been treated for or had any indication of:

a) Heart, circulatory trouble or chest pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	g) Mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) High blood pressure, stroke, blood disorder or elevated cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h) Stomach, intestinal, liver, kidney or bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Cancer, tumour or Leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	i) Chronic headaches, migraines or recurrent infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> Yes <input type="checkbox"/> No	j) Skin disorder (including acne)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Respiratory or Allergy Disorder (including asthma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	k) Alcohol or drug dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Bone or joint disorder (including arthritis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	l) AIDS, ARC (AIDS Related Complex) or other immunological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Infertility/Reproductive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
n) Have you, your spouse or any listed dependent been advised, treated or hospitalized for any physical impairment, condition, disease or disorder stated above?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
o) Have you, your spouse or any listed dependent had or currently have a referral, testing, or investigation pending or contemplated but not yet completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

10. IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS BELOW:

Question (indicate letter)	Persons Name	Condition	Treatment Dates		Type of Treatment	Result of Treatment/ Extent of Recovery
			First DD / MM / YY	Last DD / MM / YY		

Additional Information:

11. Have you, your spouse or any listed dependent smoked tobacco in the last 12 months? If yes, who: _____ Yes No

12. Are you, your spouse or any of your listed dependents pregnant*? If yes, who: _____ Due Date _____ Yes No

***Benefits for Hospital Coverage as a result of conditions arising from pregnancy are available only after eight (8) months of continuous coverage.**

Notice: You may be contacted for further information in order to process your application.

5. 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 the insurer provided the first premium is paid in full and that no change occurred in the insurability of the person(s) to be insured since the signature on the application. **30-day Right to Examine:** You have 30 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 dependents 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 (Blue Cross) and its subsidiaries¹, to collect, use and 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, 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 Canassurance Hospital Service Association. 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 the insurer is confidential; only an employee of the insurer 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 the insurer at: 185The 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 Canassurance Hospital Service Association 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 written notice of withdrawal. I also understand that withdrawal of my consent could result in Canassurance Hospital Service Association's inability 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.useblue.com 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:

*No representative is authorized to establish and/or modify a Canassurance Hospital Service Association and/or Canassurance Insurance Company 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 Canassurance Insurance Company.

For Ontario Blue Cross Use Only

Identification No.

Underwriting Approval

Signature

Dated (Day/Month/Year)

¹ Canassurance General Insurance Company Inc., Canassurance Insurance Company Inc., and CanAssistance Inc.