SASKATCHEWAN BLUE CROSS®

# DEPENDENT COVERAGE APPLICATION

**INSTRUCTIONS** **1.** Print in ink or type information.
**2.** Include all eligible members of your family on this application.
**3.** *A dependent is the applicant's spouse, unmarried child up to 18 years of age or 25 years of age if enrolled in full-time education, or an infirm child unable to leave the applicant's care. Indicate **D** if physically or mentally disabled. For dependents 18 and over, indicate **S** if a full-time student.

**Based on your medical history you may be given a higher rating, excluded from specific benefits or declined.**

**4.** Only **permanent** residents of Saskatchewan are eligible for coverage.
**5. ALL APPLICANTS ARE REQUIRED TO COMPLETE PARTS I & II.**
**6.** Complete **PART III DETAILED MEDICAL INFORMATION** if your policy includes Optional Benefits Prescription Drugs, Hospital Cash or *LifeLink*® Critical Conditions. Failure to complete for all applicants may result in unnecessary delays.

| *FOR BLUE CROSS USE ONLY* |
|---|
| Policy No. |
| Broker No. |

## PART I BASIC INFORMATION

Last Name First Name

Mailing Address

City or Town Province Postal Code

Home Phone Number ( ) - Daytime Phone Number ( ) -

Email Cell Phone Number ( ) -

Does your spouse/dependent currently have Blue Cross coverage? ☐ Yes ☐ No
If YES, Policy No._____

Does your spouse/dependent have coverage with another insurer? ☐ Yes ☐ No
If YES, Company Name. _____

Are you a permanent resident of Saskatchewan? ☐ Yes ☐ No

**INDIVIDUAL REGISTRATION (Include only person(s) to be added)**

| Last Name / First Name & Initial(s) | Sex M/F | Birth Date Yr. | Mo. | Day | S or D* | Sask. Health Services # | Height** | Weight** | Physician |
|---|---|---|---|---|---|---|---|---|---|
| Spouse | | | | | | | | | |
| Children | | | | | | | | | |
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** Indicate the measurement used for height (feet and inches or cm) and weight (kg or lbs).

## PART II MEDICAL INFORMATION

1. Has any listed person, during the past 2 years, consulted or received advice or treatment from a licensed chiropractor, physiotherapist/athletic therapist, psychologist, massage therapist, chiropodist/podiatrist, naturopath, acupuncturist, etc. or been advised to do so? ☐ Yes ☐ No
2. Has any listed person purchased or plan to purchase orthopaedic shoes, supplies or arch supports? ☐ Yes ☐ No
3. Does any listed person now use or in the foreseeable future need any aids such as braces, canes, walkers, wheelchairs; diabetic supplies or equipment; hearing aids; breathing aids such as oxygen, CPAP machine, nebulizers or aerochambers; ostomy supplies; hospital beds or other supplies or equipment? ☐ Yes ☐ No
4. Has any listed person consulted a physician or specialist about, been treated for, or had any known indication of: Heart Disorders, Stroke, Diabetes/impaired glucose (including diet-controlled Diabetes), Kidney or Liver Disease, Chronic Obstructive Pulmonary Disease (COPD) or Emphysema, Cancer, Arthritis, Multiple Sclerosis, Crohn's or Colitis, AIDS or other immunological disorder, or any other chronic condition? ☐ Yes ☐ No
5. Do you or any person listed have any symptom or complaint regarding your health for which you have not yet consulted a physician, or 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 (surgery, pregnancy, etc.)? ☐ Yes ☐ No

*Please Note: Maternity benefits, or conditions arising due to pregnancy, are available only after 8 months continuous coverage.*

**If you answered YES to any of the above questions, or if your policy includes Optional Benefits Prescription Drugs, Hospital Cash or *LifeLink*® Critical Conditions, please proceed to PART III DETAILED MEDICAL INFORMATION.**

**If you answered NO to all of the above questions and your policy does not include Optional Benefits Prescription Drugs, Hospital Cash or *LifeLink*® Critical Conditions, please proceed to PART IV AGREEMENT AND CONSENT.**

## PART III DETAILED MEDICAL INFORMATION

1. Have any listed persons **EVER** consulted a physician, been treated for or had any indication of:

A. Heart, chest pain, circulatory trouble or elevated cholesterol ☐ Yes ☐ No
B. High blood pressure, stroke, blood disorder ☐ Yes ☐ No
C. Cancer, tumor or leukemia ☐ Yes ☐ No
D. Diabetes/impaired glucose, Crohn's or Colitis ☐ Yes ☐ No
E. AIDS, positive HIV test or other immunological disorder ☐ Yes ☐ No
F. Alcohol or drug abuse ☐ Yes ☐ No
G. Stomach, intestinal, liver, kidney or bladder disorder ☐ Yes ☐ No
H. Bone or joint disorder (including arthritis) ☐ Yes ☐ No
I. Mental, nervous or emotional disorder (including depression) ☐ Yes ☐ No
J. Respiratory or lung disorder (including asthma, COPD, Emphysema) ☐ Yes ☐ No
K. Disease or disorder of the reproductive system or infertility ☐ Yes ☐ No
L. Chronic conditions, i.e., pain, headaches/migraines seizures, paralysis or Parkinson's disease ☐ Yes ☐ No
M. Skin disease or disorder (including acne) ☐ Yes ☐ No
N. Recurrent infections ☐ Yes ☐ No
O. Attention Deficit Disorder ☐ Yes ☐ No

## PART III DETAILED MEDICAL INFORMATION CONTINUED

**If you answered YES to any of the previous questions, please provide details below.**

| PERSON'S NAME | CONDITION | DATE FIRST TREATED | DURATION OF TREATMENT | TYPE OF TREATMENT | RESULTS OF TREATMENT/ EXTENT OF RECOVERY |
|---|---|---|---|---|---|
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2. Have any listed persons taken any prescription medication for any reason in the last 6 months or have a prescription for which refills are currently authorized (including oral medication, serum, injection, drops, creams and suppository forms)? ☐ Yes ☐ No

**If you answered YES to the above question, please provide details below.**

| PERSON'S NAME | PRESCRIPTION NAME | STRENGTH | QUANTITY TAKEN | COST PER MONTH | NO. OF REFILLS/YR. | REASON |
|---|---|---|---|---|---|---|
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3. Within the past 2 years, have any listed persons:

a) received treatment from a licensed chiropractor, psychologist, physiotherapist/athletic therapist, massage therapist, chiropodist/podiatrist, naturopath or acupuncturist? ☐ Yes ☐ No

b) used any diabetic supplies or equipment? ☐ Yes ☐ No

c) required orthopaedic shoes, orthopaedic supplies or arch supports? ☐ Yes ☐ No

d) required ambulance services or nursing care? ☐ Yes ☐ No

e) required artificial limbs, braces, walker, wheelchair or oxygen? ☐ Yes ☐ No

**If you answered YES to any of the above questions, please provide details below.**

| PERSON'S NAME | TYPE OF SERVICE | AVG. NO. OF TREATMENTS PER YEAR | DATE FIRST TREATED | DATE LAST TREATED | REASON FOR TREATMENT | RESULTS OF TREATMENT/ EXTENT OF RECOVERY |
|---|---|---|---|---|---|---|
| | | | | | | |
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4. Have any listed persons smoked tobacco in the last 12 months? ☐Yes ☐No If yes, please indicate name(s) of person(s). _____

5. Within the last 3 years, have any listed persons been hospitalized? ☐Yes ☐No
If yes, please indicate name(s) of person(s) and answer the following questions: *Date? Duration? Reason? Name of Physician? Result?*
_____
_____

6. Does any listed person have a physical impairment, disease or disorder not stated above? ☐Yes ☐No
If yes, please indicate name(s) of person(s) and provide details. _____
_____

7. Please provide details to **PART II**, question 5. _____
_____

## PART IV AGREEMENT AND CONSENT

I, the undersigned, 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. 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, 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.

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-USEBLUE®.

**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.**

Signature of Applicant _____

Signature of Spouse _____

Date _____

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

SASKATCHEWAN BLUE CROSS®

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