SASKATCHEWAN BLUE CROSS®

BLUE CHOICE® PERSONAL HEALTH PLAN 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.
4. Only **permanent** residents of Saskatchewan are eligible for coverage.
5. ALL APPLICANTS ARE REQUIRED TO COMPLETE PARTS I, II, III, IV AND VI.
6. Complete **PART V DETAILED MEDICAL INFORMATION** if you are applying for 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
Application No.
Broker No.

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

PART I BASIC INFORMATION

Applicant Last Name | First Name

Mailing Address

City or Town | Home Phone Number ( ) -

Province | Postal Code | Daytime Phone Number ( ) -

Email | Cell Phone Number ( ) -

Marital Status ☐ Single ☐ Married/Common Law ☐ Widowed ☐ No. of Dependent Children____ | Occupation

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

Have you had or do you currently have Blue Cross coverage?
Applicant ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
If YES, Policy No. _____

Do you or any member of your family have coverage with another insurer?
☐ Yes ☐ No
If YES, Company Name _____

INDIVIDUAL REGISTRATION

Last Name / First Name & Initial(s)	Sex M/F	Birth Date Yr.	Mo.	Day	S or D*	Sask. Health Services #	Height**	Weight**	Physician
Applicant									
Spouse									
Children									

** Indicate the measurement used for height (feet and inches or cm) and weight (kg or lbs).

PART II COVERAGE REQUESTED

	AMOUNT
☑ **Core Health Benefits**	$_____
OPTIONS: ☐ **Prescription Drugs**	$_____
☐ **Dental**	$_____
☐ **Hospital Cash**	$_____

***LifeLink*® Critical Conditions**	AMOUNT
☐ **$25,000 Option**	$_____
☐ **$10,000 Option**	$_____
☐ **VIP Annual Travel Plan**	$_____
☐ **Term Life Insurance** ***(complete enclosed form)***	

	AMOUNT
☐ **Student Accident Insurance**	$_____
☐ **$10,000 Life Option**	$_____
☐ **$5,000 Life Option**	$_____
☐ **Double-up Option**	$_____
Monthly Premium *TOTAL*	$_____
Annual Premium *TOTAL*	$_____ x12

PART III METHOD OF PAYMENT

Payment of annual premium is required with application unless paying by credit card or PAD.

☐ Pre-authorized Debit (PAD) **Please complete the enclosed PAD Agreement**
☐ Annual Billing **Payable by cheque or credit card**

PART IV MEDICAL INFORMATION – TO BE COMPLETED BY ALL APPLICANTS

1. Have you or 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 have you been advised to do so? ☐ Yes ☐ No
2. Have you or any listed person purchased or plan to purchase orthopaedic shoes, supplies or arch supports? ☐ Yes ☐ No
3. Do you or any listed person now use or in the foreseeable future need any aids such as braces, walkers, wheelchairs; diabetic supplies or equipment; hearing aids; artificial eyes; breathing aids such as oxygen, CPAP machine, nebulizers or aerochambers; ostomy supplies; hospital beds or other supplies or equipment? ☐ Yes ☐ No
4. Have you or 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 questions in PART IV or are applying for Optional Benefits Prescription Drugs, Hospital Cash or *LifeLink*® Critical Conditions, please proceed to PART V DETAILED MEDICAL INFORMATION.

If you answered NO to all of the questions in PART IV and are not applying for Optional Benefits Prescription Drugs, Hospital Cash or *LifeLink*® Critical Conditions, please proceed directly to PART VI AGREEMENT AND CONSENT.

PART V DETAILED MEDICAL INFORMATION

1. Have you or 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

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

PERSON'S NAME	CONDITION	DATE FIRST TREATED	DURATION OF TREATMENT	TYPE OF TREATMENT	RESULTS OF TREATMENT/ EXTENT OF RECOVERY

2. Have you or any listed person 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

3. Within the past 2 years, have you or 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, cane, hearing aid, 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

4. Have you or any listed persons used tobacco products in the last 12 months? ☐ Yes ☐ No If yes, please indicate name(s) of person(s). _____

5. Within the last 3 years, have you or 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. Do you or 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 IV**, question 5. _____
_____

PART VI 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®

306.244.1192 or 1.800.667.6853
sk.bluecross.ca

Pre-authorized Debit (PAD) Agreement

POLICY NUMBER

1. CUSTOMER INFORMATION (please print)

Name

Mailing Address | City | Province | Postal Code

( ) Mobile Phone Number | ( ) Work Phone Number | ( ) Home Phone Number

Email Address

2. ACCOUNT HOLDER INFORMATION (complete if different than above)

Name

Mailing Address | City | Province | Postal Code

( ) Mobile Phone Number | ( ) Work Phone Number | ( ) Home Phone Number

Email Address

3. ACCOUNT INFORMATION

Please attach a personalized cheque marked VOID or a Pre-authorized Debit Form completed by your financial institution.

4. CONSENT & AGREEMENT

- I authorize Saskatchewan Blue Cross to debit the bank account identified above in the amount of $_____ on the first business day of every month, as payment for my policy. If funds are not available on this date, the debit will be represented three (3) days later. I authorize Saskatchewan Blue Cross to present multiple payments and/or to change the amount of the debit as a result of my direct action (such as, but not limited to, a telephone instruction or other remote means), as required to maintain my policy. I will be charged a service fee for declined debits. I agree that Saskatchewan Blue Cross is not responsible for any bank service charges relating to declined debits. I will receive written notification annually of the PAD amount.
- These services are for (check one) ☐ Personal ☐ Business
- I may revoke my authorization at any time by submitting written notice to Saskatchewan Blue Cross at least ten (10) business days before the next debit date. To obtain a sample cancellation form or more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit **www.cdnpay.ca**.

Signature of Account Holder

Signature of Joint Account Holder (if applicable)

Name (please print)

Name (please print)

Date

Date

- I have certain recourse rights if any debit presented by Saskatchewan Blue Cross does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

5. SUBMIT THE COMPLETED FORM TO

Saskatchewan Blue Cross
516 Second Avenue North, PO Box 4030
Saskatoon SK S7K 3T2
Fax 306.652.5751
service@sk.bluecross.ca