SASKATCHEWAN BLUE CROSS®

TERM LIFE INSURANCE APPLICATION

INSTRUCTIONS

1. Print in ink or type information.
2. Only **permanent** residents of Saskatchewan are eligible for coverage.
3. ALL APPLICANTS ARE REQUIRED TO COMPLETE ALL PARTS OF THE APPLICATION.
4. Failure to complete all questions on this application may result in unnecessary delays.
5.* 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.

FOR BLUE CROSS USE ONLY	
Policy No.	Broker No.

PART I BASIC INFORMATION

INDIVIDUAL REGISTRATION

Last Name / First Name and Initial(s)		Sex M/F	Birth Date Yr.	Mo.	Day	S or D*	Height**	Weight**
Applicant	00							
Spouse	01							
Children	02							
	03							
	04							
	05							
	06							

BENEFICIARY _____ **Relationship to Applicant** _____

Unless otherwise indicated, the beneficiary shall be the applicant if living, otherwise the spouse if living, otherwise the estate.

Home Phone Telephone	( )	Daytime Phone Number	( )
Email		Cell Phone Number	( )

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

PART II COVERAGE REQUESTED

Only applicants 18 to 54 years of age may apply for this coverage.

- ☐ $25,000
- ☐ $50,000
- ☐ $75,000
- ☐ $100,000

Is this policy intended to replace or change any life insurance policy? ☐ **Yes** ☐ **No**

The insurer has the right to decline an application which indicates replacement is intended.

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**

MEDICAL INFORMATION BUREAU NOTICE
Please detach and retain.

Saskatchewan Blue Cross and Blue Cross Life Insurance Company of Canada® (Blue Cross Life) take reasonable and appropriate steps to protect and maintain the privacy of your personal information. Blue Cross Life or its reinsurers may make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB will, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB, as below, and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

Medical Information Bureau
501 - 330 University Avenue
Toronto ON M5G 1R7
(416) 597-0590

Blue Cross Life Insurance Company of Canada or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PART IV DETAILED MEDICAL INFORMATION

Answer each question to avoid delays in processing your application.

1. Have you or any family member to be insured ever consulted a physician for, been treated for or had any indication of:

a) chest pain, heart or circulatory disorder? ☐ Yes ☐ No

b) high blood pressure or stroke? ☐ Yes ☐ No

c) cancer, tumor or leukemia? ☐ Yes ☐ No

d) kidney, digestive or liver disorder? ☐ Yes ☐ No

e) diabetes or respiratory disorder? ☐ Yes ☐ No

f) mental, emotional or nervous system disorder? ☐ Yes ☐ No

g) alcohol or drug abuse? ☐ Yes ☐ No

h) AIDS, positive HIV test, or other immunological disorder? ☐ Yes ☐ No

2. Have you or any family member to be insured consulted a physician, had an x-ray, electrocardiogram, or other medical test performed within the last five years (excluding regular annual checkups, common cold, pregnancy, minor fractures or lacerations)? ☐ Yes ☐ No

3. Do you or any family member to be insured have a physical impairment, disease or disorder not stated above? ☐ Yes ☐ No

IF YOU ANSWERED YES TO ANY QUESTION ABOVE, PLEASE PROVIDE FULL DETAILS BELOW.

PERSON'S NAME	ILLNESS OR CONDITION	NAME & ADDRESS OF PHYSICIAN &/OR HOSPITAL PROVIDING TREATMENT	DATE & DURATION OF TREATMENT	TYPE OF TREATMENT RECEIVED	RESULTS OF TREATMENT & EXTENT OF RECOVERY

4. Have you or your spouse used any nicotine or smoking cessation product in any form in the past 12 months? ☐ Yes ☐ No

5. During the past 3 years, have you or any family member to be insured had your driver's licence suspended or revoked, or been convicted of a) 3 or more driving violations, b) refusing to take a breathalyzer test, or c) driving while impaired? If yes, please provide details. ☐ Yes ☐ No

_____

_____

6. 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

If yes, please provide details. _____

_____

_____

PART V 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, the Medical Information Bureau, 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 (if spousal coverage is applied for)

Date _____

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

INFORMATION STATEMENT

This is not a contractual obligation. Accidental Death & Dismemberment, Life and Critical Conditions benefits are underwritten by Blue Cross Life Insurance Company of Canada, an independent licensee of the Canadian Association of Blue Cross Plans, PO Box 220, Moncton NB E1C 8L3.

10 Day Right to Examine Policy:

You have 10 days from the receipt of the policy to examine it and return for cancellation and a full refund of monies paid.

SASKATCHEWAN BLUE CROSS®

Saskatoon Office
516 2nd Avenue North
PO Box 4030
Saskatoon SK S7K 3T2
306.244.1192

Regina Office
100-1870 Albert Street
Regina SK S4P 4B7
306.525.5025

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