

I.D. No.:

APPLICATION FOR GUARANTEED ISSUE HEALTH PLAN

Please print in ink or type information.

Agent Branch Client

BLUE CRUSS

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-800-667-4511	TEL: 1-800-667-4511	TIMOUTH FO BOX 2200 HAL	IFAN INO DOJ O	co Ficase	e print in ink or ty	pe illiorillation	
APPLICANT'S PERSONAL INFORMA	ATION						
Applicant's Last Name (Applicant must be age 16	or older):		First N	ame:			
Language Preference: English							
*E-mail address:							
Address (Street & No.):							
City/Town:				Posta	al Code:		
Telephone No.: -			-		- -		
HOME *Your policy will be issued by email.		WO	RK		MOBILE		
Requested Effective Date of Policy: Pleas	se begin my coverage	on the 1st day of (mo	onth/vear):				
Do you currently have any health and dent			., .				
If yes, is this application intended to replace		_					
If this is replacing your current policy, plea			n (optional):			
Carrier:	ID	Number:	· 	Pe	olicy Number:		
Health and Dental Benefits (Mandator	y)	\mathscr{S}					
Prescription Drugs (Optional - choose	one)	Standard Drug Pl					
Traval Barraft (Ontional)		Premium Drug Pl					
Travel Benefit (Optional)							
First Name	La	ast Name	Sex M/F	Date of Birth DD MM YY	Please (🗸) if you or your dependents DO NOT wish Drug coverage	Full-Time Student	
Applicant	00				2138 2213182		
Spouse**	01						
Child	02						
Child	03						
Child Child	04						
** Spouse shall mean an individual who is marri		esides at the same addr	ess as the ap	oplicant.			
Are you and all listed dependents currentl Insurance (MSI) in Nova Scotia, Hospital ar	y covered by a Provi	ncial Health Plan in A	tlantic Car	nada (Medicare in New B			
Yes No If no, please explain:							
AGREEMENT							
I, the undersigned, hereby apply for the benefi	its offered under the G	Guaranteed Issue Healt	h Dlan from	n Medavie Blue Cross as o	utlined in the Guara	intend Issue	
Health Plan policy. I confirm the information I I					atimod in the Guard		
I understand that the personal information pro Cross and/or Blue Cross Life Insurance Comp I am an eligible member, to recommend suitab I carry, limited personal information may be co professionals or institutions, life and health ins benefits outlined in the policy of which I am an	any of Canada, may be le products and servic llected from and/or re urers, government and	e collected, used, or dis es to me, and to manag leased to a third party.	sclosed to ac ge Medavie I These third	dminister the terms of my p Blue Cross's business. Dep I parties include other Blue	policy or the group pending on the type Cross organization	policy of which of coverage s, health care	
I understand that my personal information will doing so may prevent Medavie Blue Cross from am aware of the risks and benefits of consenting	m providing me with th	e requested coverage					
Your personal information will be securely stor inside and outside of Canada. All service provi	red using information s	ystems owned or mana				oroviders, both	
I authorize Medavie Blue Cross to collect, use	and disclose my perso	onal information as des	cribed above	e.			
Dated on this	day of			year	·		
Signature of Applicant		Signature of Spouse / Cohabitant (as defined in policy)					
A photocopy of this authorization shall be as regarding Medavie Blue Cross's privacy polic		This consent complies	with federa	al and provincial privacy la	ws. For additional i	nformation	
EOD MEDAVIE BLUE CROSS LISE OF	M V						

CASH OFFICE: Amount Received:

PLEASE COMPLETE THE PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT BELOW. I/We authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I/we may authorize at any time), to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited from my/our specified account on the first business day of every month. Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information. This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca. I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca. Type of Service: Personal Business Please attach a void cheque. (Credit card payments are not accepted.) Financial Institution (FI): ______ City/Town: ______ Province: ____ Postal Code ____ | Address: FI Transit Number: FI Account Number: (transit - 5 digits; FI - 3 digits) Would you like your claim reimbursements automatically deposited in the same account? _____ Authorized Signature(s): ____ If someone other than the policy owner will be paying the premium, please have them sign and date above and complete their personal information below. Address: Telephone Number (Business): | | | | | | | | | | | | | | | | | | Refunds for any overpayment are to be made payable to the applicant. FOR AGENT USE ONLY I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products. _____ Agent's Number: _____ Agent's Name: Address: ____ Province: ______ Postal Code: _____ | City/Town: Telephone Number: E-mail address: Agent's Signature: ___ **QUOTATION WORK SHEET:** Health & Dental:

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied.

Accidental death and dismemberment benefits will be underwritten by Blue Cross Life Insurance Company of Canada.

All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.





Drugs: Travel Total:

Agent Comments: ____