Blue Choice® Health Care Plan Application Form

Instructions:
1. All shaded areas for Ontario Blue Cross use only.
2. Print in ink, or type information.

Broker Affiliate ID: _____

3. All applicants must complete parts I, II and IV and **sign the application form.**
4. If applying for Hospital Coverage and Prescription Drug options, please complete Parts I, II, III and IV.

ONTARIO BLUE CROSS™

Part I: Basic Information

You must be a valid OHIP member to apply

Applicant's Last Name | First Name

Address - Street & No. | City or Town

Province: ONTARIO | Postal Code

Email

Applicant's Telephone No. (Home) ( )

Applicant's Telephone No. (Business) ( )

Marital Status
- ○ Single
- ○ Couple
- ○ Family
- ○ Single Parent

Coverage Applied For
- ○ Core Health Benefits Only
- ○ Hospital Coverage Only
- ○ Core Health Benefits and Hospital Coverage

Options
- ☐ Prescription Drugs
- ☐ Dental

Have you had or do you now have Blue Cross Coverage?
○ Yes ○ No
If yes, please indicate :

Policy ID No. _____

Province _____

Termination Date : ___/___/___
dd / mm / yyyy

Group Policyholders Only:
☐ Conversion Plan

Occupation

Agent: HealthQuotes.ca Inc.
Agent No.: 52 00 0108

Individual Registration
Minimum applicant age is 18 years.

		Last Name	First Name and Initial(s)		Sex (M/F)	Birth Date (D/M/Y)	Height (in./cm)	Weight (lb/kg)
Applicant				00		/ /		
Spouse				01		/ /		
Children	1			02		/ /		
	2			03		/ /		
	3			04		/ /		
	4			05		/ /		

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

Information Statement

For contracts of this type, Ontario Blue Cross anticipates that 75% of the subscriber dues will be required for claims.This is not a contractual obligation. **30 Day Right to Examine Policy:** 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.

Payment Options * Send No Money Now *

Choose Mode of Payment

☐ **Credit Card** ○ MasterCard ○ Visa ○ Amex

Credit Card No. |__|__|__|__| |__|__|__|__| |__|__|__|__| |__|__|__|__| Expiry Date ___ / ___ (Month/Year)

○ Annual Payment ○ Monthly Payment

Cardholder"s signature
X

☐ **Monthly Bank Withdrawal** If subscriber dues are to be paid by pre-authorized monthly withdrawals, please complete and sign this section. Please include one of your personal cheques marked "Void".
I hereby authorize Ontario Blue Cross to draw debits in its favour for payment of my Ontario Blue Cross Coverage. This authorization may be cancelled upon written notice.

Bank Name | Signature of account holder(s) **X**

Bank Address | (if joint Account) **X**

☐ **Annual Bill** You will receive an annual bill statement that will be sent with your policy.

Part II: Medical Information

To be completed by all applicants.

1.	Have you 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 been advised to do so?	○ Yes ○ No
2.	Have you or any listed dependent purchased during the past two years or plan to purchase orthopaedic shoes, supplies or arch supports?	○ Yes ○ No
3.	Have you 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.)?	○ Yes ○ No
4.	Have you or any listed dependent required ambulance services or nursing care during the past two years?	○ Yes ○ No
5.	Have you or any listed dependent consulted a physician 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, leukaemia 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)?	○ Yes ○ No

If you have answered "yes" to any of the above questions, please provide details below, proceed to next page, and complete Parts III and IV of the application, providing full details. If you have answered "no" to all of the above questions and are not applying for Hospital Coverage, and Prescription Drug options, please proceed directly to Part IV, on the next page.

For Ontario Blue Cross Use Only

Identification No.	Underwriting Approval Signature Date

Part III: Detailed Medical Information

To be completed when applying for Hospital Coverage and Prescription Drug options, or if any questions in Part II have been answered "yes".

Applicant	Spouse
1a. Name and address of personal physician	**2a.** Name and address of personal physician
1b. Date last consulted (D/M/Y) _____ / _____ / _____	**2b.** Date last consulted (D/M/Y) _____ / _____ / _____
1c. Findings and/or treatment	**2c.** Findings and/or treatment

Part III: Detailed Medical Information

3. Are you 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

If Answer is "Yes", Please Provide Details:

Person's Name	Prescription Name	Strength	Daily Qty.	Reason	Cost/Presc.	# of Refills/Yr

4. Have you or any listed dependent **EVER** consulted a physician or specialist, been treated for or had any indication of : (Check yes or no for all questions)

A. Heart, circulatory trouble or chest pain ◯ Yes ◯ No

B. High blood pressure, stroke, blood disorder or elevated cholesterol ◯ Yes ◯ No

C. Cancer, tumour or leukaemia ◯ Yes ◯ No

D. Diabetes, Colitis or Crohn's ◯ Yes ◯ No

E. Respiratory or Allergy Disorder (including asthma) ◯ Yes ◯ No

F. Bone or joint disorder (including arthritis) ◯ Yes ◯ No

G. Mental, nervous or emotional disorder ◯ Yes ◯ No

H. Stomach, intestinal, liver, kidney or bladder disorder ◯ Yes ◯ No

I. Chronic headaches, migraines or recurrent infections ◯ Yes ◯ No

J. Skin disorder (including acne) ◯ Yes ◯ No

K. Alcohol or drug dependency ◯ Yes ◯ No

L. AIDS, ARC (AIDS Related Complex) or other immunological disorder ◯ Yes ◯ No

M. Infertility/Reproductive disorder ◯ Yes ◯ No

5. Have you or any listed dependent been advised, treated or hospitalized for any physical impairment condition, disease or disorder not stated above? ◯ Yes ◯ No

6. Have you or any listed dependent had or currently have a referral, testing, or investigation pending or contemplated but not yet completed? ◯ Yes ◯ No

If Answer is "Yes" to 4, 5 or 6 Please Provide Details:

Quest. No.	Person's Name	Condition	Date First Treated	Date Last Treated	Type of Treatment	Result of Treatment/ Extent of Recovery
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Additional Information

7. Have you or any listed dependent smoked tobacco in the last 12 months? ◯ Yes ◯ No If so, who? _____

8. Are you or any of your listed dependents pregnant? ◯ Yes ◯ No Due Date __/__/__ Who? _____

9. Should we require further information to process your application may we phone you during work hours:

At home? ◯ Yes ◯ No Most Convenient Time _____ At Work? ◯ Yes ◯ No Most Convenient Time _____

Maternity benefits for conditions arising due to pregnancy are available only after eight (8) months of continuous coverage.

Part IV: Agreement and Consent

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 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.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, any government health agency or other medically related facility that has any records or knowledge of me or my health or the health of my covered dependents to give Ontario Blue Cross any such information. A photographic copy of this authorization shall be as valid as the original.

I agree that no coverage is in effect unless and until my application is approved by Ontario Blue Cross.

	X	X
Dated (Day/Month/Year)	Signature of Applicant	Signature of Spouse