



INDIVIDUAL PLAN APPLICATION

(Please complete both sides in ink)

Group ID YOUBOU
(For Broker/Agent Use only)

Pacific Blue Cross (PBC), PO Box 7000, Vancouver, BC V6B 4E1 Phone: 604 419-2200 Toll-free 1 888 275-4672 Fax: 604 419-2199 Street Address: 4250 Canada Way, Burnaby, BC

Part 1: APPLICANT

Last Name		First Name		Initial	Date of Birth mo day yr			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address				City	Postal Code		Daytime Phone Number		
S.I.N. (if not provided, PBC will issue an ID Number)					British Columbia Care Card Number				

Part 2: DEPENDENTS (Please list children you wish to be covered in oldest to youngest order.)

	Last Name	First Name	Initial	Sex	Date of Birth mo day yr	British Columbia Care Card Number
Spouse:						
Child:						
Child:						
Child:						
Child:						

Spouse means your legal spouse, or a common-law spouse with whom you have been continuously living for the past 12 months. **Child** means a single, unemployed person under age 21 (**19 years of age for Dental Only Plan**), who is a natural or adopted child of yours or your spouse, and who is financially dependent on you or your spouse. If such child is physically or mentally disabled prior to attaining age 21 coverage may continue beyond age 21 (**19 years of age for Dental Only Plan**). If you have more than four dependent children, please list them on a separate sheet.

PART 3: BENEFICIARY DESIGNATION

Please name at least one Beneficiary (and Trustee, if a Beneficiary is under age 18), otherwise applicable Benefits will be paid to your estate in the event of your death.

Beneficiary's Full Legal Name	% of proceeds	Relationship to you	Trustee's Full Legal Name

PART 4: APPLICATION STATUS (Please check (✓) the relevant boxes.)

I am **NOT** converting from a Group Extended Health Plan. I would like coverage to start on _____ (mo/day/yr)
(If you are applying for Health coverage, complete Part 7. See Note Below.)

I am applying for Dental coverage only. My Extended Health coverage is with (name of company & plan number): _____
(Note: MSP is not Extended Health coverage.)

I am **Converting** from an PBC/Blue Cross **Group Plan** which terminated/will terminate on _____ (mo/day/yr), and which was in force for at least six months.
My Group Plan has/had the following benefits: Extended Health Eyeglasses/Contact Lenses Dental Dentures
If converting from any other insurance company, please complete Part 7 of this application.
My Group Plan was/is with: **PBC** **OR** **Blue Cross** (state province) in _____
My Group Number was/is _____ My Group Plan ID Number was/is _____
Please list all applicable Dependents who were/are covered under this Group Plan for at least 6 consecutive months prior to the proposed start date of coverage under the Plan for which you are now applying. If same as those in Part 2, check this box only.

Are you covered by any other private Group Health or Dental Plan (e.g. Spouse's plan through employment)? Yes No

Note: If you are not eligible to convert coverage from a group plan, you must complete the Pre-existing Condition Declaration in Part 7. Your Application will be accepted regardless of your medical condition. If you are converting coverage, we must receive this application within 60 days of the date of termination of your Group Plan. You will be billed from the termination date of your Group Plan.

PART 5: PLAN SELECTION (Please check (✓) 2 boxes to indicate the plan and payment mode you want. (Rates and Application are valid until June 1, 2010)

		Enhanced Extended Health	Enhanced Extended Health & Dental
	Single Rate (\$)	<input type="checkbox"/> 65.00/month <input type="checkbox"/> 739.00/year	<input type="checkbox"/> 110.00/month <input type="checkbox"/> 1,259.00/year
	Couple Rate (\$)	<input type="checkbox"/> 125.00/month <input type="checkbox"/> 1,423.00/year	<input type="checkbox"/> 217.00/month <input type="checkbox"/> 2,476.00/year
	Family Rate (\$)	<input type="checkbox"/> 143.00/month <input type="checkbox"/> 1,628.00/year	<input type="checkbox"/> 292.00/month <input type="checkbox"/> 3,324.00/year

PART 6: PAYMENT OPTIONS AND BANKING DETAILS (Do not provide banking details if you are paying Annually.)

I choose to pay Annually. My cheque in the amount of \$ _____ is attached.

I choose to pay Monthly by preauthorized payment. My initial cheque in the amount of \$ _____ is attached.

Note: If you are converting from a Group Plan, your cheque must cover the period from the date your group coverage terminated up to the current month (i.e. up to three months). If you are not converting from a Group Plan, your cheque should be for one month's payment.

By providing my banking details below, I authorize my bank/financial institution to allow Pacific Blue Cross/BC LIFE to withdraw monthly payments from my account beginning the 1st of _____. In my first year of coverage, each monthly payment will be \$ _____. Thereafter, the monthly payment amount may change for each subsequent 12 month period effective on the anniversary date of my Plan. Unless I instruct otherwise, Pacific Blue Cross/BC LIFE will be authorized to withdraw the relevant amount each month.

Name of Bank/Financial Institution & full address of Branch: _____

Branch No: _____ **Institution No:** _____ **Account No:** _____ **Tel: ()** _____

Signature of Account Holder(s): _____

PART 7: PRE-EXISTING CONDITION DECLARATION (Complete this section if you are NOT converting from a PBC or Blue Cross plan.)

Have you, or any Dependent named on this Application, been diagnosed with, treated, prescribed medication, or had any known indication of any of the following during the preceding 12 months? (Please check (✓) where appropriate.)

Condition	Yes No		Condition	Yes No	
	Yes	No		Yes	No
1. High blood pressure, heart or circulatory disorder, respiratory disorder, or neurological disorder.			3. Cancer, bowel, or stomach disorder.		
			4. Mental or emotional disorder, hormonal imbalance.		
2. Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or any other immunological disorder.			5. Chronic headaches, or migraine.		
			6. Diabetes, arthritis, thyroid disorder.		

If you, or any Dependents, have a physical impairment, disease, or disorder not stated above, please list these here:

If the answer to any of the above questions is "Yes", please provide details below.

Person's Name	Specific Illness or Condition	Name, Address or Phone Number of Physician, Provider, or Hospital Providing Treatment	Type of Treatment Received/Prescribed	Dates and/or Duration of Treatment

PART 8: SIGNATURE OF APPLICANT

By providing my Social Insurance Number, I authorize Pacific Blue Cross/BC LIFE to use it for identification purposes only. I understand that my dependents (if applicable) and I must be/have been covered for six continuous months under my Group Plan, prior to the date such plan terminated, in order to be eligible for any conversion privileges. Any information provided by me in relation to this contract or any other contract with Pacific Blue Cross or a Blue Cross organization may be used by you in adjudicating claims for me and my dependents. I confirm that the information provided above is true and complete.

Signature of Applicant: _____ Date _____ (mo/day/yr)

Please enclose your cheque payable to Pacific Blue Cross with this Application, and mail to us in the postage paid envelope provided.

Thank-you