

Part 8 Pre-existing Medical Conditions Declaration

Have you, or any dependent named on the application, been diagnosed with, treated, prescribed medication, or had any known indication of any condition during the past 12 months? Check (✓) where appropriate and provide details for each condition that you have checked. Expenses incurred as a result of a pre-existing condition(s) are not covered under these plans unless an applicant qualifies for conversion privileges (see Part 6.)

	YES	NO		YES	NO
AIDS, ARC (AIDS related Complex), positive HIV test or any other immunological disorder	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory, lung or allergy disorder (including asthma, chronic obstructive pulmonary disease and emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B, C or B carrier state	<input type="checkbox"/>	<input type="checkbox"/>	Chronic headaches or migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Stomach, intestinal, liver, kidney or bladder disorder (including ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	Artificial limbs, braces, walker, cane, hearing aid, wheelchair or oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Mental, nervous or emotional disorder (including depression or anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder, seizures, multiple sclerosis or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Bone or joint disorder (including arthritis or rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, tumor or leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive system disease or disorder or infertility	<input type="checkbox"/>	<input type="checkbox"/>	Chest and heart conditions	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease or disorder (including acne)	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure, stroke, blood disorder or elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hernia or bowel disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, colitis, or Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Attention deficit hyperactive disorder	<input type="checkbox"/>	<input type="checkbox"/>

If you or any of your dependents have a physical impairment, disease, or disorder listed or not listed above, 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

N/A – I/We have no pre-existing medical conditions. Please initial _____

Part 9 Payment Options Check (✓) all boxes that apply and provide applicable information.

I would like to pay Monthly Annually

A VOID cheque and/or my initial cheque in the amount of \$ _____ payable to Pacific Blue Cross for pre-authorized withdrawal on the first of the month from my bank account is attached.

or

My cheque for a full year's premium in the amount of \$ _____ payable to Pacific Blue Cross is attached.

My credit card details are below.
 Amount \$ _____
 VISA MasterCard American Express

Name on credit card _____

Sixteen digit credit card number _____

Expiry date (mm/yyyy) _____

Pacific Blue Cross may terminate coverage or change the method of payment with approval of the member to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A \$20.00 NSF fee will be charged by Pacific Blue Cross for all NSF transactions, in addition to what your financial institution may charge.

Part 10 Signature of Applicant/Contract Holder

I authorize my bank/financial institution to allow Pacific Blue Cross/BC Life to withdraw monthly payments from my account beginning the 1st day of the month of _____(mm/yyyy). 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.

By providing my Social Insurance Number, I authorize Pacific Blue Cross/BC Life to use it for identification purposes only. I confirm that the information I have provided is true and complete. I understand that I and my dependents (if applicable) must be continuously enrolled under all applicable provincial health plans in order to participate in this contract.

If I should receive a settlement against a liable third party for benefits covered under this contract, I agree to, and authorize the third party to, reimburse Pacific Blue Cross/BC Life up to the amount advanced to me pending such settlement or judgement.

I understand and agree 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, may not be covered. I understand that not accurately and fully disclosing all information requested on this application, could result in a denial of claims and a cancellation, or modification of the contract.

I understand and consent that some of the personal information provided by me and my dependents (if applicable) may be disclosed to agents and representatives of Pacific Blue Cross/BC Life and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefit coverage. I also understand and consent to the retention, use and disclosure of this personal information in accordance with Pacific Blue Cross' privacy policy. I authorize any medical practitioner, hospital, clinic, pharmacy and any British Columbia government health agency (including PharmaCare) or other medically related facility that has my health information to transfer the information to PBC. This includes my health records and the health records of my covered dependents (if applicable), and details of coverage eligibility. A copy of our privacy policy is available by contacting Pacific Blue Cross. It is also available on our Web site at www.pac.bluecross.ca.

Signature(s) of applicant(s) _____ Date _____

Name of contract holder (if different from applicant) _____

Signature of contract holder _____ Date _____

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