MANITOBA BLUE CROSS®
THECOLOUROFCARING

SELECT DESIRED PLAN: ☐ Basic Blue ☐ Medi-Blue ☐ Medi-Blue Deluxe
☐ GenX ☐ Plus Plan ☐ Plus Plan Deluxe

FOR GENERAL AGENT USE ONLY
AGENT #

PLEASE PRINT CLEARLY AND COMPLETE REVERSE SIDE

FOR BLUE CROSS USE

MANITOBA HEALTH #

LAST NAME

ADDRESS

CITY POSTAL CODE

TELEPHONE # EMAIL

SELECT DESIRED PAYMENT SCHEDULE: ☐ **MONTHLY** ☐ **QUARTERLY** ☐ **SEMI-ANNUAL** ☐ **ANNUAL**

**Note: 3-month paid waiting period applies to GenX, Plus Plan and Plus Plan Deluxe,
3-month unpaid waiting period applies to Basic Blue, Medi-Blue and Medi-Blue Deluxe.**

	FIRST NAME	GENDER	BIRTHDATE DAY	MONTH	YEAR
APPLICANT					
SPOUSE					

If applicant and spouse are not legally married please provide commencement date of cohabitation. Date _____

DEPENDENT CHILD					
DEPENDENT CHILD					
DEPENDENT CHILD					
DEPENDENT CHILD					

Note: The subscription rate is determined by the age of the oldest person to be covered.

BENEFICIARY _____
(Unless otherwise noted, your estate is your beneficiary.)

MEDICAL QUESTIONAIRE (must only be completed if applying for the Plus Plan Deluxe or Medi-Blue Deluxe)

1. In the past 12 months, have you or any listed dependent been hospitalized for a period of more than 14 days? ☐YES ☐NO
   If "Yes" please provide reasons and date(s) for each hospitalization _____
2. In the past 12 months, have you or any listed dependent been hospitalized on more than one occasion? ☐YES ☐NO
   If "Yes" please provide reasons and date(s) for each hospitalization _____
3. Within the last two years, have you or any listed dependent been diagnosed with, hospitalized or received treatment (including prescription drugs) for any of the following: stroke, heart attack, heart surgery, heart failure, angina, diabetes type 1, kidney or liver disease, chronic obstructive pulmonary disease (COPD), emphysema, crohn's or colitis or cancer? ☐YES ☐NO
4. Do you or any listed dependent have a referral, testing or investigation pending or contemplated (but not yet completed), or expect to be hospitalized in the next year for any condition listed in question 3? (not including day surgery or pregnancy) ☐YES ☐NO

SIGNATURE OF APPLICANT _____ DATE _____

If you answered "Yes" to questions 3 or 4 listed above, you are not eligible to purchase the Plus Plan Deluxe or Medi-Blue Deluxe. You are eligible to purchase the Plus Plan or Medi-Blue Plan. If you answered "Yes" to only question 1 or 2 please provide reasons for hospitalization and submit your application for review and consideration by Manitoba Blue Cross.

OTHER COVERAGE (must be completed if applying for the Plus Plan Deluxe or Medi-Blue Deluxe)

Are you or anyone listed on this application covered for prescription drugs, vision care, dental or other health benefits through another insurance company?

If "Yes", please indicate the following for each person covered (attach separate sheet if necessary):

☐ HEALTH ☐ DENTAL ☐ VISION ☐ DRUGS

NAME(S) OF INSURED NAME OF INSURANCE COMPANY

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GROUP #	COVERAGE EFFECTIVE	APPLIED AMOUNT

At any time in the past two years were you enrolled in an Individual Health Plan? ☐YES ☐NO

Are you presently a member of Manitoba Blue Cross? ☐YES ☐NO

If yes, what is your contract number? _____

APPLICATION

It is understood and agreed that (a) the statements on this application are complete, true and correctly recorded and no representations are made to induce the insurance of, and as part of the consideration for the coverage herein applied for; (b) the coverage will be effective only if this application is accepted by Manitoba Blue Cross and such coverage shall not be effective prior to the effective date as established by Manitoba Blue Cross.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by **Manitoba Blue Cross** and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy, 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 third parties include other Blue Cross Plans, health care professionals and institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy.

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, the 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 Blue Cross' privacy policies I can contact Blue Cross at 1.800.873.2583 (within Manitoba only) or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.

Date _____

Signature _____

PRE-AUTHORIZED DEBIT AGREEMENT FORM

I/we hereby authorize the financial institution indicated below to debit my/our account for all payments payable to: **MANITOBA BLUE CROSS**

_____
NAME OF FINANCIAL INSTITUTION

_____
BRANCH ADDRESS

_____
CITY PROVINCE

_____
TRANSIT NUMBER INSTITUTION NUMBER

_____
ACCOUNT NUMBER

I authorize Manitoba Blue Cross to perform a personal Pre-Authorized Debit (PAD) on the first of every month for each billing period. The amount may vary. I will notify Manitoba Blue Cross in writing of any changes to my account information. I may revoke my authorization at any time, subject to providing notice of 30 days. For more information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca. **I have certain recourse rights if any debit does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.**

Date _____

Signature _____

Signature _____

For verification purposes please enclose one of your personal cheques marked "Void."

For a joint account where more than one signature is required on cheques issued against the account, all depositors must sign.