Application for Life Insurance

Benefits are underwritten by Blue Cross Life Insurance Company of Canada

NAME OF PROPOSED LIFE INSURED

Last Name: _____ First Name: _____ Initial: _____ Mr., Miss., Mrs., Ms. _____

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: (____) _____

Date of Birth: _____ Age Last Birthday: _____ Gender: ☐ Male ☐ Female
(Day/Month/Year)

NAME OF POLICYOWNER
(If different from Proposed Life Insured)

Last Name: _____ First Name: _____ Initial: _____ Mr., Miss. Mrs., Ms. _____

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: (____) _____

Relationship to Life Insured: _____

Name of Contingent Policyowner (in case of death of policyowner):

Last Name: _____ First Name: _____ Initial: _____ Mr., Miss. Mrs., Ms. _____

Relationship to Life Insured: _____

Note: If no Contingent Policyowner is named, all of the Policyowner's rights and interest in this policy will be transferred to the Policyowner's estate at the time of death of the Policyowner.

NAME OF BENEFICIARY OR BENEFICIARIES
If more than one beneficiary, the proceeds will be divided in equal shares, unless otherwise indicated below.

Primary Beneficiary/Beneficiaries:

Name: _____ Telephone: (____) _____ Relationship to Life Insured: _____

Address: _____

Name: _____ Telephone: (____) _____ Relationship to Life Insured: _____

Address: _____

Contingent Beneficiary/Beneficiaries (optional):

Name: _____ Telephone: (____) _____ Relationship to Life Insured: _____

Address: _____

Name: _____ Telephone: (____) _____ Relationship to Life Insured: _____

Address: _____

Method of Payment

I/we herby 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

_____
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.

Physician's Note

Name (Proposed Life Insured): _____ Date of Birth: _____
(Day / Month / Year)

Please verify and respond to **Medical Questions 1 to 4** below (*Easy Access* Declaration) and sign the Physician's Verification below.

Easy Access Declaration

Please note: all questions that inquire about specific periods of time are to be answered counting back from (and including) the actual date you sign this Application.

Non-Medical Questions

- Have you smoked any tobacco or used any tobacco or nicotine in any form (including nicotine replacement products) or used any smoking cessation products in the last 12 months? ☐ Yes ☐ No
- Is this insurance coverage to replace any other existing policy? (If yes, please complete a disclosure statement form.) ☐ Yes ☐ No

Medical Questions

1. Are you currently hospitalized or confined to a ***nursing care home***[1] , OR within the last 12 months have you been hospitalized two or more times? ☐ Yes ☐ No
   1 Nursing Care Home – persons confined to a residential facility, including government and independent facilities and those operated within a hospital or retirement village, who require active daily nursing care.
2. a) Within the last two years have you been diagnosed with OR hospitalized for any of the following: stroke, heart attack, heart surgery, heart failure (water/fluid on the lungs), angina OR:
   b) Within the last three years have you been diagnosed with OR hospitalized for malignant cancer (other than basal cell carcinoma)? ☐ Yes ☐ No
3. Within the last year have you been advised by a physician to have:
   a) surgery, diagnostic testing, investigation or referral that has either not been completed or the results are unknown OR:
   b) have you used oxygen equipment to assist in breathing? ☐ Yes ☐ No
4. Have you ever been diagnosed with, treated for, had any indication of HIV infection or AIDS, OR within the last five years have you been diagnosed with ***chronic***[2] kidney or liver disease or received a major organ transplant? ☐ Yes ☐ No
   2 Chronic – A disease or condition that persists over a long period of time.

If any question is answered with a "YES," please provide complete details of any and all conditions including dates, diagnosis, treatment, results and whether the condition(s) is under control. (Attention: If this portion of the application is completed, no premium is to be forwarded until requested by Manitoba Blue Cross.)

Remarks: _____

_____

_____

If age 75 or over, the following portion must be completed by the proposed life insured's personal physician prior to submitting the completed application.

Physican's Verification

Easy Access Declaration

I have reviewed the Proposed Life Insured's answers to medical questions 1 to 4 above and to the best of my knowledge the answers given are correct.

Remarks: _____

_____

_____

_____	_____	_____
Date	Physician's Full Name (please print)	Physician's Signature

☐ **I am applying for *Easy Access* life insurance.**

If you've answered "NO" to medical questions 1 to 4 on page 4:

I understand and agree that if I've answered "NO" to medical questions 1 to 4 on page 4 on the date I've signed and dated this application, I am eligible for insurance coverage in the amount for which I've applied effective immediately provided the initial payment is paid in full, **and the physician's signature, if required, confirms the "NO" answers to the medical questions.**

If you've answered "YES" to any medical question from 1 to 4 on page 4:

If I have answered "YES" to any one of medical questions from 1 to 4 of the application, then I understand and agree that no coverage is in effect until a review of the medical history has been completed, the initial premium is paid in full and a policy is issued by Manitoba Blue Cross and Blue Cross Life Insurance Company of Canada.

I apply for ***Easy Access*** insurance and declare that all answers given concerning this application and declaration are full, complete and true. **Please be advised that any incorrectly answered questions or false statements on this *Easy Access* application or declaration may result in Manitoba Blue Cross, and Blue Cross Life Insurance Company of Canada declaring the policy void. Manitoba Blue Cross/Blue Cross Life Insurance Company of Canada reserve the right to levy an expense recovery fee under these circumstances.**

Easy Access

I, the undersigned, declare the answers to the questions on page 4 are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or 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.

Signature of Policyowner	Signature of Proposed Life Insured	Witness

Dated at:_____ on this _____ day of _____ year _____