assured access

Application

Protecting tomorrow's insurability today

MEDAVIE BLUE CROSS™

www.medavie.bluecross.ca

644 Main Street
Moncton NB E1C 8L3

230 Brownlow Avenue Dartmouth
PO Box 2200 Halifax NS B3J 3C6

Tel.: 1-800-667-4511 Fax: 506-869-9654

If you have any questions about ***Assured Access*** or ***Options Plus***, or need assistance completing the application form, please contact your Medavie Blue Cross authorized agent or sales professional today.

MEDAVIE BLUE CROSS™

assured access

Protecting tomorrow's insurability today

How would you cover prescription drug costs if you lost your group health benefits? What about the cost of trips to the physiotherapist, optometrist or dentist?

These and other routine expenses can add up quickly. Without health coverage, all routine and non-routine health care costs not eligible under a provincial health care plan come out of your pocket, and the cost can be shocking. Make the ***Assured Access*** plan from Medavie Blue Cross an important component of your financial planning process and ensure your savings are not depleted by health care costs.

WHAT IS *ASSURED ACCESS*?

Assured Access ensures that your future insurability is secured based on your health today. As we age our health often deteriorates, making it difficult to be approved for health care coverage. With ***Assured Access*** you don't have to worry about qualifying for health coverage later in life.

If you lose your group health benefits due to retirement, career change, employment cutbacks, business closure or a disability, ***Assured Access*** allows you to stay covered.

WHO IS ELIGIBLE?

Assured Access is available to anyone age 64 or under who is currently covered and has been covered under a group health benefit plan for the last 12 months. Once you qualify medically, the plan provides you and your family access to an extensive, affordable personal health plan without additional medical underwriting, if group health benefits are lost.

ASSURED ACCESS BENEFITS

Within 60 days of losing your group health benefits, you will be eligible to enrol in an ***Options Plus*** personal health plan. This plan provides comprehensive drug, hospital, travel, extended health benefits and the ***Assured Access*** module.

While your group coverage is in force, ***Assured Access*** also protects you and your family by offering you an additional $10,000 of Accidental Death and Dismemberment coverage.

* Applicants must meet medical underwriting standards at time of application.

MEDAVIE BLUE CROSS™

Options plus **Personal Health Plan**

OPTIONS PLUS PERSONAL HEALTH PLAN BENEFITS:

Prescription Drugs:
80% pay direct coverage
100% coverage after $4,500

Hospital Benefits:
100% semi-private hospital

Travel Benefits:
100% unlimited number of 30-day trips

Accidental Death and Dismemberment:
$15,000 per member, spouse or cohabitant; $5,000 per dependent child

Dental Benefits (Optional)
70% Reimbursement for:
Examinations
Cleaning
Fillings
Extractions
Root canal and more

Extended Health Benefits:
70% reimbursement for...
Vision care: up to $300 in two years
Physiotherapy: 20 treatments/year up to $490
Massage Therapy, Naturopath and Acupuncture
Other Practitioners
Orthopedic Shoes and Moulded Arch Supports
Private-duty Nursing: up to $5,600 in two years
Accidental Dental
Ambulance and Ambulance Attendant
Hearing Aids
Ostomy Supplies
Oxygen Equipment and Oxygen
Prosthetic Appliances
Braces and Splints
Diabetic Supplies
Medical Equipment

***Assured Access* Module**
Allows you to convert your personal health plan to an ***Assured Access*** plan any time you gain access to group coverage and want to put your personal health plan on hold.

If you become eligible again for group health coverage while enrolled in the ***Options Plus*** personal health plan, you may return to the ***Assured Access*** plan and place your ***Options Plus*** coverage on hold. As long as the ***Assured Access module*** is kept active, you can switch between your personal health plan and your ***Assured Access*** plan as many times as you experience a loss of group benefits.

assured access

Protecting tomorrow's insurability today

Assured Access Eligibility Check List

- ☐ All individuals to be covered under the policy must currently have group health coverage;
- ☐ All individuals to be covered under the policy must have had group health coverage for the last 12 months; and
- ☐ All individuals to be covered under the policy must be age 64 or under on the effective date of coverage.

If you meet all these requirements, please fill out the attached application form.

Individuals with group benefits from an insurer other than Medavie Blue Cross at any time during the last 12 months, please note the application form requires either a copy of your health and prescription drug claims history from this group insurer or your attending physician's signature on the application. More details are on the application.

Applicant Information

Last Name _____ First Name _____ Language Preference ☐ English ☐ French

Address

_____ _____ _____ _____
Street and Number City/Town Province Postal Code

Telephone Numbers and E-mail

_____ _____ _____ _____
(Home) (Work) (Cell) E-mail Address

Occupation _____ Employer Name _____

How long have you been continuously employed?

_____ _____
Years Months

Do all individuals applying for coverage under this application currently have group health benefits* coverage?

☐ Yes ☐ No (All individuals must have group health benefits to apply for coverage.)

Have all individuals applying for coverage under this application been covered under a group health benefits plan during the 12-month period prior to the date of application?

☐ Yes ☐ No (Individuals must have group health benefits for 12 months prior to the date of application to apply for coverage.)

Are all individuals applying for coverage currently covered by a provincial health plan within Atlantic Canada?

☐ Yes ☐ No (Medicare in New Brunswick, Medical Services Insurance in Nova Scotia, Prince Edward Island Hospital and Medical Services Plan or Newfoundland and Labrador Medical Care Plan)

If no, please explain: _____

Effective Date of Policy

Coverage commences on the 1st day of the month following approval of your application. If you wish to have coverage become effective on the 1st day of a different month, please specify which month: _____ .

The *Assured Access* rates that are in effect as of the policy effective date shall apply to this application.

* Group Health Benefits – an employer-sponsored health benefit plan consisting of three or more employees.

Please list all individuals to be covered under this ***Assured Access*** plan.
For any individual between the ages of 21 and 25, please indicate who is a full-time student.

First Name	Last Name	Sex M/F	Date of Birh DD MM YY	Full-Time Student?	Height	Weight	Smoker?	Pregnant?	Due Date DD MM YY
Applicant	00						Yes/No	Yes/No	
Spouse/Cohabitant**	01						Yes/No	Yes/No	
Child	02							Yes/No	
Child	03							Yes/No	
Child	04							Yes/No	
Child	05							Yes/No	

All individuals to be covered under the *Assured Access* policy must be age 64 or under on the effective date of coverage.

** Spouse shall mean an individual who is the husband or wife of the applicant.

Cohabitant shall mean any **one** individual named in the application by the applicant in lieu of a spouse, provided he or she resides at the same address as the applicant.
Note: a child cannot be named as a cohabitant so long as he or she qualifies as a dependent child under this policy.

FOR INTERNAL USE ONLY

Identification Number _____ Cash Office: Amount Received _____ ☐ Agent ☐ Branch ☐ Client

PART TWO MEDICAL INFORMATION – Please answer the following medical questions for all individuals.

1. Has any individual to be covered ever consulted a physician, been treated for or had any indication of:

A. High blood pressure, stroke, heart attack, heart disease, chest pain or angina? Yes ☐ No ☐
B. Asthma, allergies or other breathing problems? Yes ☐ No ☐
C. Back, neck or knee pain, muscle or joint pain, arthritis or injury? Yes ☐ No ☐
D. Stomach, intestinal, liver or kidney disorder? Yes ☐ No ☐
E. Alcohol or drug dependency? Yes ☐ No ☐
F. AIDS or HIV infection? Yes ☐ No ☐
G. Recurrent infections or elevated cholesterol? Yes ☐ No ☐
H. Diabetes, colitis, Crohn's, acne/rosacea/cold sores or skin disease/disorder or osteoporosis? Yes ☐ No ☐
I. Depression, anxiety or other mental illness, insomnia or other sleep disorder? Yes ☐ No ☐
J. Disease or disorder of the reproductive system or infertility or hormone/menopausal symptoms? Yes ☐ No ☐
K. Cancer or leukemia? Yes ☐ No ☐
L. Chronic headaches, epilepsy or multiple sclerosis? Yes ☐ No ☐
M. Within the last two years, has any individual to be covered been hospitalized OR required the services of a chiropractor, physiotherapist, psychologist or podiatrist, nathuropath, acupuncturist or massage therapist ? Yes ☐ No ☐

PLEASE PROVIDE DETAILS TO ALL YES ANSWERS TO QUESTIONS #1

Individual's Name	Condition	Type and Number of Treatments	Date First Treated	Date Last Treated	Results of Treatment/ Extent of Recovery

2. Does any individual to be covered take prescription medication or have a prescription for which refills are currently authorized? (Include all forms of medication - pills, patches, injections, drops, creams and suppositories.) ☐ YES ☐ NO If you answered yes, please provide details.

Individual's Name	Prescription Name	Reason for Medication	Strength of Medication	Quantity Taken

3. Does any individual to be covered currently have a referral, testing, treatment, investigation, surgery or appointment contemplated or completed but for which the results have not yet been received? ☐ YES ☐ NO If you answered yes, please provide Individual's Name, Condition, Date of Appointments etc.

4. Does any individual to be covered have a physical or mental impairment, disease or disorder not stated in the preceding?
☐ YES ☐ NO If you answered yes, please provide Individual's Name, Condition, Type of Treatment etc.

PART THREE AGREEMENTS

Please complete the Pre-authorized Debit (PAD) plan agreement below.

I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. **Medavie Blue Cross will not provide monthly pre-notification but will provide 30 days notice if the deduction is subject to change**. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

DATE: _____ **AUTHORIZED SIGNATURE:** _____

Type of Service: ☐ Personal ☐ Business

Please attach a void cheque or complete the form below. (Credit card payments are not accepted.)

PLEASE PRINT

Financial Institution (FI): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: |_____| (branch - 5 digits; |_____| FI - 3 digits)

FI Account Number: |_____|

If someone other than the member will be paying the premiums, please have them sign, date and complete their financial information above and complete their personal information below:

Name: _____ Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Business) ___ - ___ - _____ (Residence) ___ - ___ - _____

AGREEMENT AND CONSENT

I/We, the undersigned, understand and agree that any pre-existing condition/injury or the signs of which that appeared or occurred on or before the date of this application are not covered by the personal health plan that can be accessed through this policy. The discovery of facts known by my/our eligible dependents or me/us but not stated on this application could result in the denial of a claim and the cancellation or modification of this policy and the personal health plan that can be accessed through this policy. I/We further acknowledge that it is my/our responsibility to notify Medavie Blue Cross of any changes in my/our health status or the health of my/our dependents from the date of application until a policy is issued or the effective date, whichever is later. Medavie Blue Cross reserves the right to recover any monies paid on my/our behalf or on behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this application form. I/We agree to repay to Medavie Blue Cross any and all monies paid as a result of the discovery of facts not fully disclosed on this application.

I/We, the undersigned, declare the answers to the above questions 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 Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my/our policy, to recommend suitable products and services to me/us and to manage the Company's business. Where any individuals applying for coverage were covered under a Medavie Blue Cross group health benefits plan at any time during the 12-month period prior to the date of application, I/we authorize Medavie Blue Cross to use the group health and prescription drug claims history for that 12-month period under the plan(s) for medical underwriting purposes. I/We authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically-related facility, insurance company, government or regulatory authority, institute, organization or person that has any records or knowledge of me/us or my/our health, to give Blue Cross Life, Medavie Blue Cross or their reinsurer any such information. I/We further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/our personal physician or other medical practitioner.

I/We acknowledge and agree that there is no coverage and that Medavie Blue Cross is not at risk unless a contract comes into effect as a result of this application.

This consent is valid for as long as the contract is in force, unless I/we revoke it in writing. I/We understand I/we may revoke my/our consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I/We understand why my/our personal information is needed and am/are aware of the risks and benefits of consenting or refusing to consent. I/We can contact Medavie Blue Cross at 1-800-667-4511 should I/we have questions as to the collection, use or disclosure of my/our personal information.

This consent complies with federal and provincial privacy laws.

(A photographic copy of this authorization shall be as valid as the original.)

Dated on this _____ day of _____ year _____

_____ _____

Signature of Applicant Signature of Spouse / Cohabitant *(as previously defined)*

PART FOUR GROUP HEALTH BENEFITS INFORMATION

Please list all individuals who have had **Medavie Blue Cross** group health benefits coverage **at any time during the last 12 months.**

Name:	Policy No.:	Identification No.:	Name:	Policy No.:	Identification No.:

Individuals with group health benefits from an insurer(s) **other than Medavie Blue Cross at any time during the last 12 months** must either: (Please check one option only.)

- ☐ Provide a copy of the health and prescription drug claims history from this group insurer(s) for the period of time covered with this insurer(s) over the last 12 months, OR
- ☐ Provide a physician's verification signature(s) on this application. Please have your attending physician complete the Attending Physician's Verification section below.

ATTENDING PHYSICIAN'S VERIFICATION - The applicant is responsible for any physician charges for the completion of this section.

☐ I have reviewed the answers to medical questions 1 to 4 on page 4 and, to the best of my knowledge, the answers given are correct for the following patient(s): ☐ All of the listed individuals ☐ Only the following individual(s)

Name(s): _____

Remarks: _____

_____

Date | Attending Physician's Full Name (please print) | Attending Physician's Signature

If a family member or cohabitant has a different physician, please have the individual's attending physician complete the following.

☐ I have reviewed the answers to medical questions 1 to 4 on page 4 and, to the best of my knowledge, the answers given are correct for the following patient(s):

Name(s): _____

Remarks: _____

_____

Date | Attending Physician's Full Name (please print) | Attending Physician's Signature

AGENT INFORMATION (If applicable)

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Signature	Agent's Number	Agent's Tel. Number	Agent's Fax Number
	3750	(709) 631-0028	(709) 722-9105

Agent's Name (please print)	Agent's E-mail Address
Francis Kelly	francisgkelly@hotmail.com

Agent's Mailing Address: 7 Stamp's Lane, St. John's, NL, A1E 3C9

Agent's Comments

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied.

Accidental death and dismemberment benefits will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.

QUESTIONS?

Should you have any questions about this plan or the application itself, please contact your Medavie Blue Cross authorized agent or sales professional.