MANITOBA BLUE CROSS®

Blue Choice Plan Application

A. GENERAL INFORMATION

List all individuals to be covered under the applicant's Manitoba Blue Cross Blue Choice plan, indicating dependent's last name if different from applicant. All individuals listed must be Manitoba residents covered by Manitoba Health, Seniors and Active Living.

Last Name	First Name	Middle Initial	Gender	Date of Birth			Height	Weight
Applicant				DD	MM	YYYY	❑ ft/in ❑ cm	❑ lbs ❑ kg
Spouse/Common-law				DD	MM	YYYY	❑ ft/in ❑ cm	❑ lbs ❑ kg
Dependents				DD	MM	YYYY		
				DD	MM	YYYY		
				DD	MM	YYYY		
				DD	MM	YYYY		
				DD	MM	YYYY		

Mailing Address	City	Province	Postal Code

Home Phone Number	Daytime Phone Number	Email Address

B. SELECT YOUR BLUE CHOICE PLAN

I/We are applying for coverage under the Blue Choice plan as described in the Blue Choice brochure enclosed with this application:

❑ **Plan A** **(complete Sections A, B, D, E only if selecting Plan A)**

❑ **Plan B** ❑ **Plan C** **(complete entire application if selecting Plan B or C)**

If you require more detailed benefit information, please contact a Manitoba Blue Cross representative at 204.788.6858 or 1.800.873.2583.

Previous health benefits information:

1. Have you terminated or will you be terminating from a group benefit plan within 30 days? ❑ No ❑ Yes
2. If yes, complete the following:

Employer's Name	Carrier Name	Policy Number	Drugs	Health	Dental	Coverage End Date (dd/mm/yyyy)
			No ❑ Yes ❑	No ❑ Yes ❑	No ❑ Yes ❑	

a. Acceptance – Upon acceptance of this application Manitoba Blue Cross will confirm coverage through the issuance of identification cards within an effective date determined by Manitoba Blue Cross. The agreement will include: Blue Choice plan application, Blue Choice plan Standard Terms and Benefit Schedule along with the following, if applicable: Exclusion Agreement and/or Conversion of Blue Choice plan to any other Personal/Family plan. The Blue Choice brochure is for marketing purposes only and does not form part of the agreement.

Amendment(s) to the Blue Choice Standard Terms and Benefit Schedule will be based on Manitoba Blue Cross's assessment of all the provided information.

Manitoba Blue Cross may amend the provisions of the agreement at any time by providing 30 days written notice to the plan member.

If the plan member is not satisfied with the Blue Choice plan Terms and Benefit Schedule they may be returned to Manitoba Blue Cross for termination within twenty (20) days of receipt and all payments will be refunded.

b. Rejection – In the event that this application is rejected, Manitoba Blue Cross will destroy all of the information provided to Manitoba Blue Cross relating to this application.

C. MEDICAL INFORMATION (complete this section only if Plan B or C selected)

1. Has any applicant ever consulted a physician or medical practitioner, been treated for, or has any indication of the following:

a) Alcohol or drug abuse ? ❑ No ❑ Yes
b) Bone, joint or muscle disorder (e.g. arthritis, low bone density) ? ❑ No ❑ Yes
c) Cancer or tumour (e.g. leukemia, melanoma) ? ❑ No ❑ Yes
d) Chest pain, heart or circulatory disorder (e.g. blood clots, blocked arteries) ? ❑ No ❑ Yes
e) Diabetes or elevated blood sugar? ❑ No ❑ Yes
f) High blood pressure ? ❑ No ❑ Yes
g) High cholesterol ? ❑ No ❑ Yes
h) Recurrent infections (e.g. cold sores, Herpes virus) ? ❑ No ❑ Yes
i) Skin disorder (e.g. psoriasis, acne, eczema) ? ❑ No ❑ Yes
j) Chronic headaches, migraines or dizziness ? ❑ No ❑ Yes
k) Neurological disorder (e.g. seizures, stroke/TIA, paralysis) ? ❑ No ❑ Yes
l) Gastrointestinal disorder (e.g. ulcers, GERD, Crohn's, colitis) ? ❑ No ❑ Yes
m) Kidney or urinary disorder (e.g. enlarged prostate, overactive bladder) ? ❑ No ❑ Yes
n) Liver disorder (e.g. Hepatitis, cirrhosis) ? ❑ No ❑ Yes
o) Reproductive or hormonal disorder (e.g. low testosterone, PCOS, fibroids) ? ❑ No ❑ Yes
p) Mental health or behavioural disorder (e.g. depression, anxiety, eating disorder, ADHD) ? ❑ No ❑ Yes
q) Respiratory/lung disorder or allergies (e.g. asthma, COPD, requires EpiPen®) ? ❑ No ❑ Yes
r) AIDS, positive HIV test or other immunological disorder ? ❑ No ❑ Yes

Use this section to provide details of all Yes answers to the above questions. Use a separate page if more space is required.

Person's Name	Condition/Symptom/Disorder	Type of Treatment	Date Diagnosed (MM/YY)	Date of Last Symptoms/ Treatment (MM/YY)

2. Has any applicant taken or been prescribed any medication, (e.g. pills, creams, eye drops, inhalers, patches), for any reason, in the past 12 months? ❑ No ❑ Yes **If yes, provide full details in the table below:**

Person's Name	Drug Name & Strength	Reason for Taking	Number of Refills/Year	Start Date (MM/YY)	End Date (MM/YY) If ongoing, state "none."

3. Does any applicant have a condition, disease or disorder not listed above?

❑ No ❑ Yes (If yes, indicate details including name of applicant and type of disorder/treatment)

4. Does any applicant have an outstanding medical referral, test, or investigation pending?

❑ No ❑ Yes (If yes, indicate details including name of applicant, reason for/type of investigation, and anticipated date of completion)

5. Does any applicant have abnormal test results for which additional medical consultation has been advised?

❑ No ❑ Yes (If yes, indicate details including name of applicant, and type of investigation/consultation)

6. Does any applicant have undiagnosed signs and/or symptoms for which medical consultation is contemplated?

❑ No ❑ Yes (If yes, indicate details including name of applicant and type of symptoms/signs)

7. Please specify the name of the usual physician or medical clinic attended for each person listed.

Person's Name	Usual Physician or Medical Clinic, (if none, state "none.")

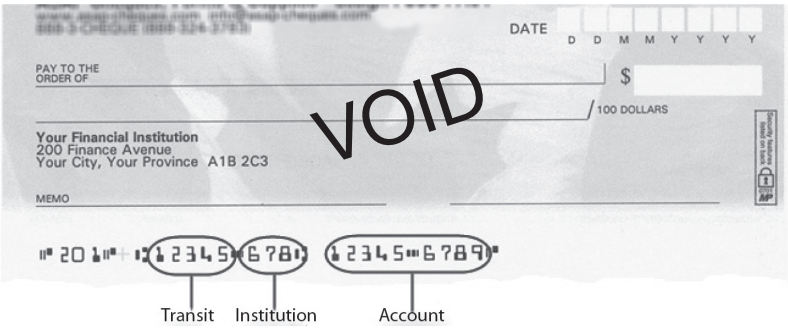
Please use a separate page if more space is required for any of the above questions.

D. MONTHLY PRE-AUTHORIZED DEBIT AND DIRECT DEPOSIT OF CLAIMS AUTHORIZATION

Please complete the information below and enclose a void cheque.

Financial Institution Name	Transit Number	Institution Number	Account Number

For verification purposes, please enclose a cheque marked void.



Pre-Authorized Debit Agreement

I authorize Manitoba Blue Cross to perform a personal Pre-Authorized Debit (PAD) on the first business day 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.**

I authorize Manitoba Blue Cross to transfer ALL claim payments to the Financial Institution indicated above. Please include all signatures required for cheque endorsement.

Authorized Signature _____ **Date** _____

Second Authorized Signature (if required) _____ **Date** _____

E. AUTHORIZATION AND CONSENT

Failure to complete this application in its entirety will result in delays. Upon receipt of a completed application with all the required information and verification of medical information, Manitoba Blue Cross will provide a response to this application for coverage within 30 days. Applicants, co-applicants and dependents must cooperate fully with Manitoba Blue Cross in verifying the information provided and understand that a failure to cooperate may lead to the application being rejected or the agreement being cancelled. If all the required information is not received within 60 days, the application will be closed.

I/we 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/our plan; verify my/our eligibility for coverage; verify, assess and pay claims; develop and recommend suitable products and services to me/us; and to manage the company's business.

Depending on the type of coverage I/we 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 or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the plan of which I/we are an eligible member.

I/we certify that the member is authorized by his/her spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes.

I/we understand that my/our personal information will be kept confidential and secure. I/we understand that 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 are aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I/we can contact Manitoba Blue Cross at 1.800.873.2583 or mb.bluecross.ca should I/we have questions as to the collection, use or disclosure of my/our personal information.

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

A photographic copy of this authorization shall be as valid as the original. This consent complies with provincial and federal privacy legislation.

I/we have read and understand the entire application and certify that all questions are answered fully and completely. I/we understand that facts known by me/us or listed dependents – but not stated on the application – could result in the denial of coverage, denial of a claim, modifications of the rate or cancellation of the agreement.

Date _____ /_____ /_____
DD MM YYYY

This consent will be valid from this date, will continue while this agreement is in force and will end when agreement is cancelled.

Signature of Applicant _____

Please print name here _____

Signature of Spouse/Common-law _____

Please print name here _____

All three pages of this application must be completed

AGENTS USE ONLY

AGENT'S NAME (Please print if applicable)	COMPANY NAME	AGENT'S SIGNATURE	
Lori Yorke	Medi-Quote Insurance Brokers Inc.		
MAILING ADDRESS	EMAIL ADDRESS	TELEPHONE NUMBER	AGENT NUMBER
505 Pandora Ave W - Winnipeg MB R2C 1M8	info@mediquote.ca	204-947-9210	764

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