ALBERTA BLUE CROSS®

# INDIVIDUAL PLANS – ADD DEPENDENT

## A. PARTICIPANT INFORMATION:

| Applicant's last name | First name | Middle initial | Group number | Section | I.D. number |
|---|---|---|---|---|---|
| | | | | | |

| Address | City | Province | Postal code |
|---|---|---|---|
| | | | |

| Home phone number: | Daytime phone number: | Best time to call: | E-mail address: |
|---|---|---|---|
| | | | |

## B. ADD DEPENDENT(S): All individuals being added must be covered under the Applicant's Alberta Health Care Insurance Plan account.

| CO-APPLICANT/SPOUSE: Last name | First name | Middle Initial | Gender (M / F) | Date of birth yyyy / mm / dd | Height | Weight |
|---|---|---|---|---|---|---|
| | | | | / / | ❑ft/in ❑cm | ❑lbs ❑kg |

| Name of physician, medical doctor or clinic last visited: | Reason for visit (If reason given as checkup, what problem/symptoms did you have?): |
|---|---|
| Date of last visit (yyyy/mm/dd): | Indicate all findings, treatment or recommended follow-up (If none, state "none."): |

**UNMARRIED DEPENDENT CHILDREN:** (Note: If additional space is required place attach a separate page.)

| Last name (if different than applicant) | First name | Middle Initial | Gender (M / F) | Date of birth yyyy / mm / dd |
|---|---|---|---|---|
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## C. MEDICAL INFORMATION: (All questions must be answered completely.)

In order to be considered for Personal Choice / Blue Choice Plan coverage, Alberta Blue Cross must have complete medical history of the Applicant, Co-Applicant and all Dependents to be covered. Any injury or sickness, the signs of which first appeared on or before the date of this Application must be fully disclosed in this Application. Alberta Blue Cross and Blue Cross Life Insurance Company of Canada reserve the right to reject coverage, or rate or exclude certain benefits for an Applicant, Co-Applicant or Dependent based on Alberta Blue Cross's assessment of your/their medical history. Applicants/Co-Applicants and Dependents must cooperate fully with Alberta Blue Cross in verifying the information provided and understand that your failure to cooperate may lead to the Application being cancelled.

**1. Has any person listed in Section B been prescribed or is currently taking any medication for any reason in the past 12 months?**

❑ **No** ❑ **Yes - Please check one.** If yes, provide details below (include pills, creams, drops, inhalers, patch, suppository, etc.).

| Person's name | Prescription name and strength | Dose and frequency used | Number of refills/year | Reason for taking |
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**2. Has any person listed in Section B ever consulted a physician or medical practitioner, been treated for, or had any indication of:**

a) Alcohol or drug abuse ❑No ❑Yes

b) Bone or joint disorder (ie. arthritis, low bone density, etc.) ❑No ❑Yes

c) Cancer, tumour or leukemia ❑No ❑Yes

d) Chest pain, heart or circulatory abnormalities ❑No ❑Yes

e) Diabetes or elevated blood sugars ❑No ❑Yes

f) High blood pressure or elevated cholesterol ❑No ❑Yes

g) Recurrent infections (ie. Herpes virus, UTIs, etc.) ❑No ❑Yes

h) Skin disorder (ie. acne, eczema, etc.) ❑No ❑Yes

i) Chronic headaches, migraine headaches, dizziness ❑No ❑Yes

j) Neurological disorder (ie. seizures, stroke, paralysis, etc.) ❑No ❑Yes

k) Gastrointestinal, kidney or liver disorder (ie. ulcers, GERD, Colitis, Crohn's, Hepatitis, etc.) ❑No ❑Yes

l) Psychological, mood, nervous, emotional or behavioural disorder (ie. depression, anxiety, bipolar, Attention Deficit Disorder, etc.) ❑No ❑Yes

m) Respiratory, lung disorder or allergies (ie. asthma, sleep apnea, COPD, etc.) ❑No ❑Yes

n) AIDS, positive HIV test or other immunological disorder ❑No ❑Yes

o) Chiropractic services (specifically in the last 12 months) ❑No ❑Yes

p) Physiotherapy services (specifically in the last 12 months) ❑No ❑Yes

q) Psychological counselling (specifically in the last 12 months) ❑No ❑Yes

## C. MEDICAL INFORMATION (continued): (All questions must be answered completely.)

**Use this section to provide details for all Yes answers to the questions in C2. (Use a separate page if more space is required.)**

| Person's name | Illness, medical condition | Type of treatment | Date diagnosed | Date last treated | Current status |
|---|---|---|---|---|---|
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**3. Does any person listed in Section B have any physical impairment, condition, disease or disorder not listed in question C2 or require a medical aid** (ie. hearing aid, braces, wheelchair, CPAP, artificial eye, prosthesis, etc.)?

❑No ❑Yes If yes, provide details:

**4. Does any person listed in Section B have any outstanding tests, investigations, referrals or recommended follow-ups?**

❑No ❑Yes If yes, provide details:

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

## D. ACKNOWLEDGEMENT AND CONSENT: (Please read, date and sign below.)

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, Alberta Blue Cross will provide a response to this Application for coverage within 30 days. Applicants/Co-Applicants and Dependents must cooperate fully with Alberta Blue Cross in verifying the information provided and understand that your 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.

a. **Acceptance** – Upon acceptance of this Application, Alberta Blue Cross will confirm coverage through the issuance of identification cards with an effective date determined by Alberta Blue Cross. The Agreement will include: *Personal Choice / Blue Choice Plan Application*, *Personal Choice / Blue Choice Plan Standard Terms and Benefit Schedule* along with the following, if applicable: Exclusion Agreement, Rating Agreement and Conversion of Personal Choice / Blue Choice Plan to Health Plus Plan. The Personal Choice / Blue Choice Individual Health Plan brochure is for marketing purposes only and does not form part of the Agreement.

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

   Alberta Blue Cross may amend the provisions of this Agreement at any time by providing 30 days written notice to the plan Member.

   If the plan Member is not satisfied with the *Personal Choice / Blue Choice Plan Terms and Benefit Schedule* they may be returned to Alberta Blue Cross for termination within (20) days of receipt and all payments will be refunded.

b. **Rejection** – In the event that this Application is rejected, Alberta Blue Cross will return all of the information provided to Alberta Blue Cross. All other information relating to this Application will be destroyed.

**Use of your personal information**

I/we understand that the personal information provided herein as well as other personal information currently held or collected in the future by Alberta Blue Cross and/or Blue Cross Life Insurance Company of Canada will only be collected, used, or disclosed to administer the terms of my/our Personal Choice / Blue Choice Plan; verify my/our eligibility for coverage; verify, assess and pay claims; and develop and recommend suitable products and services to me/us. I/we acknowledge and agree that my/our or my dependents' personal information may only be collected from and/or released to a third party (health care professional / practitioner / institution or insurer/agent of record) only when needed for a purpose stated above. 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.

**Your acknowledgement and consent**

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. I/we have read and understood this complete Application, including this Acknowledgement and Consent, and agree to all terms and conditions of the Agreement. I/we agree that this consent shall be effective from the date of the Application and shall remain in effect as long as the Agreement is in force, unless I revoke it in writing. I/we authorize the collection, use and disclosure of my/our personal information as described above.

I/we hereby apply for the Health and Dental Coverage underwritten by Alberta Blue Cross. Head Office: 10009 108 St. NW, Edmonton, Alberta T5J 3C5. I/we hereby apply for the Accidental Death Insurance underwritten by Blue Cross Life Insurance Company of Canada. Corporate Office: 644 Main Street, P.O. Box 220, Moncton, New Brunswick E1C 8L3.

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 understood the entire Application and certify that all questions are answered fully and completely. I/we understand that facts known by myself/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** (yyyy/mm/dd)**:** **20** ___ ___ / ___ ___ / ___ ___

***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 Co-Applicant/Spouse:** ✘ _____

**Please print name here:** _____

**Both pages of this application must be completed**