QUÉBEC BLUE CROSS®

CAA QUÉBEC MD WORKS FOR YOU

HEALTH INSURANCE APPLICATION FORM

Blue Flex®

Instructions

1. Please complete the application form using ink.
2. Complete all areas of the application, including all questions & details.
3. **Missing information will delay the processing of your application.**
4. Remember to sign and date your application.
5. Original application is required. Photocopies are not accepted.

Please send your completed insurance application to the following address:
Québec Blue Cross
PO BOX 910 STN B
Montréal QC H3B 9Z9

❑ New application

❑ Modification (addition/review), contract no.: ________________

For administration only

Contract no.: ________________

Primary Insured: ________________

Spouse (if insured): ________________

1. Personal information

	Last name	First name	Sex	Date of birth YYYY/MM/DD	Height (cm/in)	Weight (kg/lbs)
Primary Insured			☐ F ☐ M	/ /		
Spouse			☐ F ☐ M	/ /		
Dependent child(ren)*			☐ F ☐ M	/ /		
			☐ F ☐ M	/ /		
			☐ F ☐ M	/ /		

Address	No.	Street	Apt.
	City	Province	Postal Code
Phone number	Home	Work	Ext.
Email		**CAA-Quebec member no.**	6 2 0 2 8 5

2. Eligibility conditions

Each person to be insured must:
- **Hold a valid card from the Régie de l'assurance maladie du Québec (RAMQ).**
- **Meet the Québec Blue Cross underwriting criteria for the selected plan.**

Primary Insured and spouse:
- **Must be between the ages of 18 and 59.**

***Dependent child(ren):**
- **Is more than 14 days old and less than 21 years of age, or;**
- **Is less than 25 years of age and is duly enrolled as a full-time student in an educational institution.**

3. Health coverage choice

1) Check the selected benefits below.
2) Indicate the amount of the premium by referring to the monthly premium leaflet.
3) Complete the health questionnaire applicable to your choice of coverage.

1st MONTH FREE

Benefits	Optional benefits	Monthly premium	Applicable health questions
❑ Extended Health Care	❑ Extended Prescription Drugs ❑ Dental Care ❑ Monthly Indemnity (in the event of an accident or an illness)	$	Choice of coverage WITHOUT the Monthly Indemnity benefit, complete **Questionnaire A**. Choice of coverage WITH the Monthly Indemnity benefit, complete **Questionnaire B**.
❑ Monthly Indemnity in the event of an accident or an illness **ONLY*** ❑ 24 months ❑ 60 months * I choose coverage with the Monthly Indemnity benefit in the event of an accident or an illness without any other benefit. I understand that an additional fee of $12 for the year will be applied to the premium.		$	Complete **Questionnaire B**.

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4. MEDICAL INFORMATION – based on your medical history, you may be declined or excluded for specific benefits.

Questionnaire A - Complete the following questionnaire if the Monthly Indemnity benefit is **not part** of your coverage.

Do you and your spouse and/or dependents have valid RAMQ Cards?
☐ Yes ______ Initials ☐ No ______ Initials

Important: Please note that this coverage is offered exclusively to Québec residents who hold valid Québec Health Insurance Cards.
No other person is eligible for this insurance, even if the premium has been accepted by Québec Blue Cross.

To be completed by all applicants:	
1. Have you or any listed dependents consulted and/or received advice or treatment from a registered specialist or therapist (chiropractor, physiotherapist, psychologist, massage therapist, etc.) during the past two years, or have you been advised to do so?	☐ Yes ☐ No
2. Have you or any listed dependents purchased, during the past two years or plan to purchase orthopaedic shoes, supplies or arch supports?	☐ Yes ☐ No
3. Have you or any listed dependent rented/purchased during the past two years or plan to rent/purchase assistive devices (artificial limbs, braces, etc.), medical equipment or supplies (walker, wheelchair, oxygen, CPAP machine, ostomy supplies etc.)?	☐ Yes ☐ No
4. Have you or any listed dependent required ambulance services or nursing care during the past two years?	☐ Yes ☐ No
5. Have you or any listed dependent consulted a physician or specialist about, been treated for or had any known indication of: heart or circulatory disorder, angina, heart attack, arrhythmia (irregular heartbeat), TIA (mini-stroke) or stroke, insulin dependent diabetes, chronic kidney or liver disease, Chronic Obstructive Pulmonary Disease (COPD) or emphysema, leukemia or cancer (excluding basal cell carcinoma), multiple sclerosis, motor neurone disease, Alzheimer's disease, Parkinson's disease, senile dementia or any inheritable disorder (such as polycystic kidney disease or Huntington's Chorea)?	☐ Yes ☐ No

6. **If you answered YES to any of the questions above**, please provide details below. Complete the Additional Information section on the following page as well as the last part of the current section by providing all details. If you answered **NO** to all of the questions, please go to question 9 on the next page.

Name	Date	Details – If space does not allow for a full description of the details, please use the 'Additional Information' section on the next page of this application.

7. **Please complete the information below if you answered YES to any of the questions numbered 1 through 5.**

Primary Insured	Name and address of personal physician:	Date consulted (YY/MM/DD):
	Reason for consultation (health problem(s) or symptoms)?	
	Findings and/or treatment:	
Spouse	Name and address of personal physician:	Date consulted (YY/MM/DD):
	Reason for consultation (health problem(s) or symptoms)?	
	Findings and/or treatment:	
Dependent child(ren)	Name and address of personal physician:	Date consulted (YY/MM/DD):
	Reason for consultation (health problem(s) or symptoms)?	
	Findings and/or treatment:	

Please complete the information below if you answered **YES** to any of the questions numbered 1 through 5.						
8. Are you or any listed dependent currently taking any prescription medication, have a prescription FOR WHICH REFILLS are authorized, or have a prescription that has not been filled as of yet? Please provide details if the answer is **YES**.						☐ Yes ☐ No
Person's Name	Name of Medication	Dosage	Daily Qty.	Reason	Cost per Presc.	# of Refills/Yr.

Please answer each of the following questions by checking **YES** or **NO**.			
9. Have you or any listed dependent EVER consulted a physician or specialist, been treated for or had any indication of:			
a) heart, circulatory trouble or chest pain?	☐ Yes ☐ No	g) mental, nervous or emotional disorder?	☐ Yes ☐ No
b) high blood pressure, stroke, blood disorder or elevated cholesterol?	☐ Yes ☐ No	h) stomach, intestinal, liver, kidney or bladder disorder?	☐ Yes ☐ No
c) cancer, tumour or leukemia?	☐ Yes ☐ No	i) chronic headaches, migraines or recurrent infections?	☐ Yes ☐ No
d) diabetes, colitis or Crohn's?	☐ Yes ☐ No	j) skin disorder (including acne)?	☐ Yes ☐ No
e) respiratory or allergy disorder (including asthma)?	☐ Yes ☐ No	k) alcohol or drug dependency?	☐ Yes ☐ No
f) bone or joint disorder (including arthritis)?	☐ Yes ☐ No	l) AIDS, ARC (AIDS Related Complex) or other immunological disorder?	☐ Yes ☐ No
m) infertility/ieproductive disorder?			☐ Yes ☐ No
n) Have you or any listed dependent been advised, treated or hospitalized for any physical impairment, condition, disease or disorder stated above?			☐ Yes ☐ No
o) Have you or any listed dependent had or currently have a referral, testing, or investigation pending or contemplated but not yet completed?			☐ Yes ☐ No

10. **If you answered YES to any of the above questions**, please provide details below:						
Question (indicate letter)	Person's Name	Condition	Treatment Dates		Type of Treatment	Result of Treatment/ Extent of Recovery
			First YY/MM/DD	Last YY/MM/DD		
Additional Information:						

11. Have you or any listed dependent smoked tobacco in the last 12 months? If so, who: ______________________________	☐ Yes ☐ No

12. Are you or any of your listed dependents pregnant? If yes who: ______________________________ Due date __________	☐ Yes ☐ No

NOTICE: You may be contacted for further information in order to process your application.

Questionnaire B - Complete the following questionnaire if the Monthly Indemnity benefit is **included** in your coverage.	
During the last five years, has the Primary Insured:	
1. taken any medication?	☐ Yes ☐ No
2. made a claim for accident or illness?	☐ Yes ☐ No
3. been hospitalized?	☐ Yes ☐ No
4. had chiropractic, surgical, medical or psychological treatment? (possible additional questionnaire)	☐ Yes ☐ No
5. suffered epilepsy, diabetes, thyroid or other endocrine disorder or had dizzyness or convulsions?	☐ Yes ☐ No
6. suffered accident sequelae, physical defect or fracture?	☐ Yes ☐ No
7. planned to consult a doctor or other health professional or have an operation?	☐ Yes ☐ No
8. consumed alcohol? If yes, how much per week? _______________________ What is consumed: beer, wine or liquor? _____________________________	☐ Yes ☐ No
9. been medically advised to drink less alcohol? (possible additional questionnaire)	☐ Yes ☐ No
10. taken narcotics (in particular morphine or heroin) without a medical prescription, amphetamines, LSD, marijuana, cocaine or other drugs? (possible additional questionnaire)	☐ Yes ☐ No
11. practiced dangerous sports (mountain climbing, car racing, parachuting, deep-sea diving, etc.)? (possible additional questionnaire)	☐ Yes ☐ No
12. had an insurance application declined, suspended, withdrawn or accepted with special conditions?	☐ Yes ☐ No
13. suffered eye or ear disease?	☐ Yes ☐ No
14. over the last 12 months, used tobacco in any form? Daily consumption: ____	☐ Yes ☐ No

To his/her knowledge, over the last five years, has the Primary Insured had any of the following disorders or symptoms:	
15. headaches, strokes, brain or nervous system disorders?	☐ Yes ☐ No
16. nervous depressions, depressive states, anxiety or burn-out?	☐ Yes ☐ No
17. asthma, bronchitis, tuberculosis, pleuritis, emphysema, coughing up of blood, persistent cough, lung or respiratory disease? (possible additional questionnaire)	☐ Yes ☐ No
18. high blood pressure, elevated cholesterol, chest pain, heart murmur, heart attack, heart or, circulation disorders?	☐ Yes ☐ No
19. ulcers, recurrent indigestion, intestinal bleeding, colitis, jaundice, hemorrhoids, hernia or gastric, intestinal, rectal, gall bladder, liver or pancreatic disorder? (possible additional questionnaire)	☐ Yes ☐ No
20. sugar, albumin, pus or blood in the urine, nephritis, kidney or bladder stone disorders?	☐ Yes ☐ No
21. cancer, tumour, gout, skin disease, venereal disease or a prostate or genital disorder?	☐ Yes ☐ No
22. low back pain, discopathy, rheumatism, arthritis, paralysis, muscle or bone pain, muscle or bone disease or stiffness — including joints, back, neck and spinal column? (possible additional questionnaire)	☐ Yes ☐ No
23. lymphadenopathy, anemia, allergies, glandular or blood disorders?	☐ Yes ☐ No
24. nose or throat disease?	☐ Yes ☐ No
25. acquired immunodeficiency disease (AIDS), AIDS Related Complex (ARC) or any other immunological disorder?	☐ Yes ☐ No

If you answered YES to any of the questions above, please provide details below

Question No.	Person's first name	Details of diagnosis, treatment, medication and current condition	Date of each occurrence	Symptom duration	Duration of absence from work	Names and addresses of physicians and medical establishments

5. Payment method

EXCLUSIVE OFFER FOR CAA-QUEBEC MEMBERS: 1ST MONTH FREE

☐ **Cheque (annual)**

The premium amount is 11 times the amount of the monthly premium.

☐ I am enclosing a cheque payable to Québec Blue Cross for the amount of $ ____________.______

☐ **Credit Card (monthly)** Please indicate the card number and the expiry date; sign and date the authorization.

☐ ☐ ☐ Card number | | | | | | | | | | | | | | | | | Exp. : | | |

Month Year

I, the undersigned, hereby authorize Blue Cross Canassurance to debit my credit card selected above monthly, on the date indicated below or on the following business day, for the sum of $__________.______, in payment of my insurance contract.

Cardholder's signature ______________________ Date ______________

☐ **Automatic Bank Withdrawal (monthly)** **Pre-Authorized Debit (PAD)**

A. Payer's information (please print)				
Account Holder	Last Name		First Name	
Joint Account Holder	Last Name		First Name	
Address	No.	Street		Apt.
	City	Province	Postal Code	
	Phone number (home)	Mobile	Email	

B. Bank account information			Type of service: personal
Financial Institution			
Address	No.	Street	
	City	Province	Postal Code
	Institution No.	Branch No.	Account No.

C. Pre-Authorized Debit (PAD)

1. I, the undersigned, hereby authorize Blue Cross Canassurance, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $__________.______, in payment of my insurance contract. If no date is entered, **I understand that the date may be determined by the Insurer without giving me prior notice.**

☐ **I have attached a cheque in the amount of $________________representing the 1st premium.**

☐ **I have attached a void sample cheque. Desired withdrawal date: ________________ (excluding the 29th, 30th and 31st).**

I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing in respect of my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all pre-authorized debits (PADs) withdrawn from my account are fixed or variable-amount personal PADs.

2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to send me prior notice of thirty (30) days only for the renewal of my policy.

3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution. I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.

4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten (10) business days prior to a PAD.

5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service department at 1-800-363-3958. **I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD.**

6. I understand that I may revoke this authorization at any time subject to providing ten (10) days' notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit **www.cdnpay.ca**.

7. I understand that the Insurer may cancel this Agreement upon thirty (30) days' written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.

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

D. Signature

Signature of Account Holder	Signature of Joint Account Holder (if applicable)
Name: ______ (please print)	Name: ______ (please print)
Date: ______ (YYYY/MM/DD)	Date: ______ (YYYY/MM/DD)

6. Signature(s)

Failure to complete this application in its entirety will result in delays.

Contract Effective Date: The contract will become effective on the date of approval by the insurer provided the first premium is paid in full and that no change occured in the insurability of the person(s) to be insured since the signature on the application. **10-day Right to Examine:** You have 10 days from the effective date of your policy to examine and return it for refund of monies paid, if you are not entirely satisfied.

When applying for this coverage, I understand that I must provide Québec Blue Cross with my complete medical history and that of any family member applying for coverage. I have read over the application and certify that all questions are answered fully and correctly. I understand and agree that any injury that occurred on or before the date of this application or any sickness which appeared on or before the date of this application must be fully disclosed on this application and may not be covered. I understand and agree that it is my obligation to inform Québec Blue Cross of any change in my health or in that of any family member applying for coverage due to either injury or illness, which occurs after the date of this application and prior to the effective date of the policy.

Any omission or false declaration could result in the denial of a claim and the cancellation or modification of the policy. I agree that this application, any supplemental information as required by Québec Blue Cross, and the policy shall constitute the entire contract. **NOTICE REGARDING PERSONAL INFORMATION:** I hereby authorize Canassurance Hospital Service Association (Blue Cross) and its subsidiaries1 , to collect, use and disclose any personal information regarding myself and/or my dependent children from and to the following individuals and organizations: any licensed medical practitioner or licensed health professional, hospital, clinic or medical related facility, any other insurance company, including any reinsurance company, or any other person or organization with information relevant to my claim or coverage, and any other person or organization that provides information services or insurance services to, or that acts as an insurance intermediary for Canassurance Hospital Service Association.

Québec Blue Cross aims to ensure the greatest confidentiality possible. All of your personal information is kept in a file titled "Insurance File". The information held by the insurer is confidential; only an employee of the insurer may consult your file, and only if justified as part of his or her job. As well, unless you object, this information may be used for personal solicitations by mail or by telephone. You may consult your file and correct the information as needed by writing to the insurer at: 550 Sherbrooke West, Montréal, Québec, H3A 3S3.

This consent is valid for the length of time necessary for Canassurance Hospital Service Association to achieve the purposes mentioned in the Notice regarding personal information. I understand that I may withdraw this consent at any time by giving Canassurance Hospital Service Association written notice of withdrawal. I also understand that withdrawal of my consent could result in Canassurance Hospital Service Association's inability to provide coverage or pay claims. A photocopy of this authorization is as valid as the original. For further details, please contact us by phone.

I agree that no coverage is in effect unless and until my application is approved by Québec Blue Cross.

Date (YYYY/MM/DD)	Signature of Applicant:	Signature of Spouse:

Income Tax Receipt

Income tax receipts are mailed before February 28 of the following year. Please notify Blue Cross of any change of address.