ALBERTA BLUE CROSS®

PERSONAL CHOICE PLAN APPLICATION

Personal Choice individual health plans for you and your family

Please fill out the following Personal Choice Plan Application. This three page Application forms part of your Agreement for the Personal Choice Plan. This Application will not be considered for acceptance unless it is completed in ink and all questions are answered fully and completely. Please print.

The Personal Choice Plan Application contains three sections:

- **Page 1 – General Information and Plan Selection**
- **Page 2 – Medical Information**
- **Page 3 – Payment & Authorization, Acknowledgement and Consent**

A. GENERAL INFORMATION: A

List all individuals covered under the Applicant's Alberta Health Care Insurance Plan account, indicating Dependent's last name if different from Applicant.

Last name	First name	Middle initial	Gender (M / F)	Date of birth	Height	Weight
Applicant				yyyy / mm / dd / /	❑ ft/in ❑ cm	❑ lbs ❑ kg
Co-Applicant/Spouse				yyyy / mm / dd / /	❑ ft/in ❑ cm	❑ lbs ❑ kg
Dependents				/ /		
				/ /		
				/ /		
				/ /		
				/ /		
				/ /		

Address	City	Province	Postal Code

Home phone number:	Daytime phone number:	Best time to call: ❑ a.m. ❑ p.m.	E-mail address:

Applicant's 9-digit Alberta Personal Health Number (PHN):

required | | | | | | | — | | | | |

B. SELECT YOUR PERSONAL CHOICE PLAN:

I/we are applying for coverage under Personal Choice Plans as described in the *Personal Choice Individual Health Plan* brochure enclosed with this Application:

❑ Plan A ❑ Plan B ❑ Plan C

If you require more detailed benefit information than the Personal Choice Individual Health Plan brochure or require the *Personal Choice Plan Standard Terms,* please contact an Alberta Blue Cross representative.

Previous health benefits information:

1. Have you, or will you, be terminating from a group benefit plan within 30 days? ❑ No ❑ Yes

2. If yes: For Alberta Blue Cross plans, complete the following:

Name of employer:	Group number:	I.D number:	Termination date:

3. For other plans, attach a Group Conversion form. (This form must be completed by your group plan administrator.)

4. If you have the Non-Group plan (Group 1), would you like it cancelled if you are accepted on this plan? ❑ No ❑ Yes

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

In order to be considered for Personal 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 rejected or the Agreement being cancelled.

1. Applicant's last visit to a medical doctor:

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

2. Co-Applicant's/Spouse's last visit to a medical doctor:

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

3. Has any person listed in Section A taken or been prescribed 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 & strength	Dose & frequency used	Number of refills/year	Reason for taking

4. Has any person listed in Section A 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

Use this section to provide details for <u>all</u> Yes answers to the above questions. (Use a separate page if more space is required.)

Person's name	Illness or medical condition	Date diagnosed	Type of treatment	Date last treated	Current status

5. Does any person listed in Section A have any physical impairment, condition, disease or disorder not listed above <u>or</u> require a medical aid (ie. hearing aid, braces, wheelchair, CPAP, artificial eye, prosthesis, etc.)?

❑No ❑Yes If yes, provide details:

6. Does any person listed in Section A have any outstanding tests, investigations, referrals or recommended follow-ups?

❑No ❑Yes If yes, provide details:

7. Has any person listed in Section A consulted and/or received advice or treatment in the last 12 months from any of the following? If yes, provide details:

Chiropractor ❑No ❑Yes Physiotherapist ❑No ❑Yes Psychologist ❑No ❑Yes

Person's name	Type of treatment	Number of treatments	Date last treated	Reason

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

ALBERTA BLUE CROSS®

PERSONAL CHOICE RATES

RATE CHART (Monthly rates for **each** family member)

PLAN TYPE	AGE					
	4 AND UNDER	5 - 20 *	21 - 34	35 - 44	45 - 54	55 - 64
PLAN A	$ 10.00	$ 25.00	$ 41.00	$ 42.00	$ 47.00	$ 56.00
PLAN B	$ 11.00	$ 26.00	$ 52.00	$ 54.00	$ 63.00	$ 74.00
PLAN C	$ 13.00	$ 32.00	$ 63.00	$ 66.00	$ 84.00	$ 100.00

* If all applicants are under 21 years of age then one of the applicants must use the 21 - 34 rates listed above.

INSTRUCTIONS

1. Select your plan type.
2. Using the Rate Chart above, insert the rate for each family member into the Rate Calculation amount column.
3. All individuals covered under the Applicant's Alberta Health Care Insurance Plan account must be on the same Personal Choice plan.
4. Add the rate(s) within the amount column to determine your Total Monthly Rate.
5. Enclose a minimum of two months payment.
6. Enclose a voided cheque for automatic monthly payment withdrawals.

RATE CALCULATION

PERSON COVERED	AMOUNT
APPLICANT	
SPOUSE	+
DEPENDENTS	+
	+
	+
	+
	+
	+
	+
TOTAL MONTHLY RATE	=

- **These rates are subject to change without notice.**
- **Acceptance of the above noted rates does not constitute acceptance of the Agreement.**
- **Rates stated above may change pending medical underwriting.**
- **Please include the required initial payment with your fully completed application form.**

D. PAYMENT OPTIONS & AUTHORIZATION:

A

Please refer to the Personal Choice Plan Rates enclosed to determine the total monthly rate. Please select from one of the payment options below:

☐ **Monthly** — **Total Monthly Rate x 2** (two months of payments) = $ _____

Please enclose your required payment plus a blank cheque marked "Void"

I, the account holder, authorize Alberta Blue Cross to debit my account at the Financial Institution indicated on the enclosed cheque. I agree to the terms and conditions established by Alberta Blue Cross until such time as written notice to the contrary is given by me to Alberta Blue Cross.

Authorization Signature:
(As required by Financial Institution) ✘ _____

☐ **Quarterly** — **Total Monthly Rate x 3** (three months of payments) = $ _____

☐ **Semi-Annual** — **Total Monthly Rate x 6** (six months of payments) = $ _____

☐ **Annual** — **Total Monthly Rate x 12** (twelve months of payments) = $ _____

Please select your preferred payment frequency from the options provided. **Your initial payment must be included with your application.** Alberta Blue Cross will invoice you by mail for all future payments based on your original payment.

E. 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 Plan Application*, *Personal Choice Plan Standard Terms and Benefit Schedule* along with the following, if applicable: Exclusion Agreement, Rating Agreement and Conversion of Personal Choice Plan to Health Plus Plan. The Personal Choice Individual Health Plan brochure is for marketing purposes only and does not form part of the Agreement.

   Amendment(s) to the *Personal 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 Plan Terms and Benefit Schedule* they may be returned to Alberta 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, 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 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): _____

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:

All three pages of this Application must be completed

AGENT'S USE ONLY

AGENT'S NAME (Please print, if applicable)	COMPANY NAME	AGENT'S SIGNATURE
BRIAN OGDEN	OGDEN FINANCIAL PLANNERS	
MAILING ADDRESS		TELEPHONE NUMBER
40-WENTWORTH SQ. SW. CALGARY AB T3H0E2		403-228-0901