ALBERTA BLUE CROSS®

Thank you for your interest in an Alberta Blue Cross Individual Health Plan.

As you complete your application, please remember to include the following:

- ❑ Complete banking information (including Branch Number, Financial Institution Number and Account Number). Alberta Blue Cross will debit the initial payment, withdraw subsequent monthly payments and directly deposit claims payments to the account provided.
- ❑ Your authorization signature on the application form for automatic payment withdrawal and direct deposit of claims payment.
- ❑ Current date on the Acknowledgement and Consent section of the application.
- ❑ Your signature and the signature of Co-Applicant/Spouse on the Acknowledgement and Consent section of the application.

Please ensure you have spoken with one of our licensed representatives prior to submitting an application for coverage. If you have any questions regarding the attached information, I can be reached in Edmonton at 780-498-8471 or toll-free province-wide at 1-800-394-1965, extension 8471.

We cannot review your eligibility for coverage until this application has been **fully completed** and returned to us.

Your completed application can be faxed to 780-498-3529 (toll free at 1-877-498-3529), or mailed to Alberta Blue Cross at the Edmonton address listed below.

Sincerely,

Jo-Ann Jacques
Individual Products
Alberta Blue Cross
10009 108 Street
Edmonton, AB T5J 3C5
780-498-8471

Blue CHOICE®

Individual health plans for you and your family through ***all*** ages and stages of life

ALBERTA BLUE CROSS®

As a consumer, you make choices every day. Why should your health benefits be any different?

Blue Choice plans help you and your family stay healthy by providing practical benefits that you'll use on a regular basis and affordable protection against the high cost of unexpected illness and accidents. You get access to a wide range of benefits to support you through ***all*** ages and stages of life.

*Simply **choose** the plan options that meet your needs and **apply today**.*

Extended health benefits

Select desired level of benefits	Level A	Level B	Level C
Overall extended health benefit maximum *(excludes AD&D, travel and term life)*	$5,000 per year	$5,000 per year	$5,000 per year
Ambulance services	100% ground and air	100% ground and air	100% ground and air
Accidental dental care	$2,000 per incident	$2,500 per incident	$3,000 per incident
Hospital cash		$20 per day; $400 per year	$20 per day; $600 per year
Preferred hospital accommodations *(semi-private or private rooms)*		$2,000 per year	$3,000 per year
Hospital beds		$1,500 per lifetime	$1,500 per lifetime
Home nursing		$3,000 per year	$5,000 per year
Auxiliary care			$1,000 per year
Individual Assistance Program (IAP)	12 sessions per calendar year	12 sessions per calendar year	12 sessions per calendar year
Psychologist	$75 per visit; $150 per year	$75 per visit, $750 per year	$75 per visit, $750 per year
Chiropractor		$35 per visit	$35 per visit
Physiotherapist		$50 per visit	$50 per visit
Massage therapist		$50 per visit	$50 per visit
Combined maximum *(chiropractor, physiotherapist and massage therapist)*		$350 per year	$500 per year
Podiatrist and chiropodist		$25 per visit; $300 per year combined maximum	$25 per visit; $300 per year combined maximum
Acupuncturist, homeopath, osteopath and naturopath			$50 per visit; $350 per year combined maximum
Vision care *(including eye exams)*		$200 every two years	$250 every two years
Travel *($5 million maximum; terminates at age 70*)*	10 days per trip (terminates at age 70*)	17 days per trip (terminates at age 70*)	30 days per trip (terminates at age 70*)
Travel plan discount (additional coverage)	15%	20%	25%
Stability clause	90 days	90 days	90 days
Term life** *(terminates at age 55*)*	$10,000 (terminates at age 55*)	$10,000 (terminates at age 55*)	$10,000 (terminates at age 55*)
Accidental Death and Dismemberment (AD&D)**	$15,000	$20,000	$25,000

Custom braces		$750 every two years	$750 every two years
Foot orthotics		$200 per year	$200 per year
Orthopedic shoes		$250 per year	$250 per year
Wheelchair		$1,500 every three years	$1,500 every three years
Medical aids *(crutches, canes, casts, cervical collars, walkers, splints, trusses and traction kits)*		$250 per year	$250 per year
CPAP *(sleep apnea appliance)*		$500 every five years	$750 every five years
Hearing aids		$500 every four years	$750 every four years
Ileostomy/colostomy, urinary catheters and supplies		80%; $1,200 per year	80%; $1,200 per year
Surgical stockings		$200 per year	$200 per year
Mastectomy prosthesis		$200 for single; $400 for double every two years	$200 for single; $400 for double every two years
Prosthetics		$300 per year	$300 per year
Oxygen and equipment		$2,500 per year	$2,500 per year
Blood pressure monitor		$150 every five years	$150 every five years

Dental benefits *(usual and customary basis of payment)*

Select desired level of benefits	Level A	Level B	Level C
Basic and preventive care *(three-month waiting period)* includes checkups, cleanings, fillings, extractions and root canals	70%	75%	80%
Maximum	$600 per year	$600 per year; first year	$600 per year; first year
Dentures *(one-year waiting period)*		50%	50%
Periodontics *(one-year waiting period)*		50%	80%
Extensive *(two-year waiting period)* includes crowns, bridges and implants			50%
Orthodontic *(two-year waiting period)*			50%; $2,000 lifetime maximum
Second and subsequent years maximum *(combined basic and extensive)*		$1,250 per year	$1,500 per year

Prescription drug benefits

Select desired level of benefits	Level A	Level B	Level C
Coverage level	70% reimbursement	70% direct bill	80% direct bill
Prescription drug maximum *(includes diabetic supplies, contraceptives, smoking cessation and vaccines)*	$10,000 per year***	$10,000 per year***	$10,000 per year***

* *"Terminates at age"* references the age when a benefit is no longer available for that specific individual.
** Underwritten by Blue Cross Life Insurance Company of Canada.
*** Reduces to $2,000 per year once any individual turns 65

Build a plan as unique as you are in two easy steps.

Step one

Review the benefits that fit your life and health needs.

Example: Carl and Joanne are a married couple with two young daughters. Carl suffers from back pain that requires regular massages. Blue Choice Plan B extended health benefits include $350 per year for massage, chiropractor or physiotherapy. He chooses to pair this with Level C dental benefits to ensure his family is protected in case his daughters require orthodontic work in the future and prescription drug Level B to save out-of-pocket expenses with direct billing of drug claims.

Step two

Contact Alberta Blue Cross and we will walk you through the online application process.

It's quick, easy and secure.

Blue Choice Portability

In the future, you may have an opportunity to acquire group benefits through an employer. But there's no need to leave your Blue Choice plan behind. By converting to the Blue Cross Portability, you maintain the option to resume coverage in the future without a medical review by contacting us within 30 days of when your employer plan terminates. This guarantees you and your family will always have access to an Alberta Blue Cross individual plan, regardless of what medical conditions may develop.

BALANCE®
Your life ▲ Your rewards

Your Blue Choice plan includes exclusive access to Balance, our online wellness resource to support and promote your health.

BLUE ADVANTAGE®

You will also enjoy access to Blue Advantage, a program that enables Alberta Blue Cross plan members to save on medical, vision care and many other products and services regardless of whether the item is covered under your benefit plan or not.

Enjoy the benefits of a Blue Choice individual health plan—apply today.

Contact us to discuss plan options
1-800-394-1965 (toll free)
780-498-8008 (Edmonton) 403-294-4032 (Calgary)
coverage@ab.bluecross.ca

Ipsos Alberta's Most Loved Brands

ALBERTA BLUE CROSS®

www.ab.bluecross.ca

ALBERTA BLUE CROSS®

Blue CHOICE®

BLUE CHOICE PLAN APPLICATION

Please fill out the following Blue Choice plan application. This application forms part of your agreement for the Blue Choice plan. If all questions are not answered fully and completely.

Please submit this completed form only by fax or mail.	FAX to Individual Products Sales 780-498-3529 or toll free 1-877-498-3529	MAIL to Alberta Blue Cross Individual Products Sales 10009 108 Street NW Edmonton AB T5J 3C5

A. General information

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

Last name	First name	Middle initial	Gender (M/F)	Birth date (YYYY-MM-DD)	Height	Weight
Applicant					☐ ft/in ☐ cm	☐ lbs ☐ kg
Spouse					☐ ft/in ☐ cm	☐ lbs ☐ kg
Dependants						

Address	City	Province	Postal code

Cell phone number	Home/alternative phone number	Best number to reach you ☐ Cell ☐ Home/alternative

Best time to call ☐ Morning ☐ Afternoon	Primary email address

B. Select your Blue Choice plan

Please select the desired level of coverage from each benefit category below. Your selection will apply to all persons listed in section A.

☐ A ☐ B ☐ C Extended health benefits

☐ A ☐ B ☐ C Dental benefits

☐ A ☐ B ☐ C Drug benefits

If you require more detailed benefit information than the Blue Choice plan brochure or require the Blue Choice plan contract, please contact an Alberta Blue Cross representative at 1-800-394-1965.

Previous health benefits information

1. Has the applicant or spouse terminated or will be terminating from a group plan or individual plan within 31 days? ☐ Yes ☐ No
2. If yes, complete the following

Employer's name (if applicable)	Carrier name	Drug ☐ Yes ☐ No	Dental ☐ Yes ☐ No	Termination date (YYYY-MM-DD)

3. If you are enrolled in the Non-Group plan (Group 1), would you like it cancelled if you are accepted on this plan? ☐ Yes ☐ No

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

C. Medical information (all questions must be answered completely) 08

To be considered for coverage, we must have accurate and complete medical history of all persons listed in section A. Any injury or sickness, the signs of which first appeared on or before the date of this application must be fully and accurately disclosed. We reserve the right to reject coverage or exclude certain benefits based on our assessment of the medical history. You must cooperate fully with us in verifying the information provided and understand that failure to cooperate may lead to the application being rejected.

1. Has any person listed in section A ever consulted a physician or medical practitioner, been treated for or had any indication of the following: (please check yes or no for each question; if yes, provide details below)

a) alcohol or drug abuse	☐ Yes ☐ No	k) neurological disorder (e.g. seizures, stroke/TIA, paralysis)	☐ Yes ☐ No
b) bone, joint or muscle disorder (e.g. arthritis, low bone density)	☐ Yes ☐ No	l) gastrointestinal (e.g. ulcers, GERD, Crohn's, colitis)	☐ Yes ☐ No
c) cancer or tumor (e.g. leukemia, melanoma)	☐ Yes ☐ No	m) kidney or urinary disorder (e.g. enlarged prostate, overactive bladder)	☐ Yes ☐ No
d) chest pain, heart or circulatory disorder (e.g. blood clots, blocked arteries)	☐ Yes ☐ No		
e) diabetes or elevated blood sugar	☐ Yes ☐ No	n) liver disorder (e.g. hepatitis, cirrhosis)	☐ Yes ☐ No
f) high blood pressure	☐ Yes ☐ No	o) reproductive or hormonal disorder (e.g. low testosterone, PCOS, fibroids)	☐ Yes ☐ No
g) high cholesterol	☐ Yes ☐ No	p) mental health or behavioural disorder (e.g. depression, anxiety, eating disorder, ADHD)	☐ Yes ☐ No
h) recurrent infections (e.g. cold sores, herpes virus)	☐ Yes ☐ No	q) respiratory/lung disorder or allergies (e.g. asthma, COPD, requires EpiPen®)	☐ Yes ☐ No
i) skin disorder (e.g. psoriasis, acne, eczema)	☐ Yes ☐ No	r) AIDS, positive HIV test or other immunological disorder	☐ Yes ☐ No
j) chronic headaches, migraine headaches or dizziness	☐ Yes ☐ No		

Use this section to provide details for all yes answers to the above questions (use a separate page if more space is required)

Person's name	Illness, medical condition	Type of treatment	Date diagnosed (YYYY-MM-DD)	Date of last symptoms and treatment (YYYY-MM-DD)

2. Has any person listed in section A taken or been prescribed any medication, (e.g. pills, creams, eye drops, inhalers, patches), for any reason in the past 12 months?

☐ **Yes** ☐ **No** If yes, provide details below

Person's name	Drug name and strength	Reason for taking	Number of refills per year	Start date (YYYY-MM-DD)	End date (YYYY-MM-DD) *if ongoing, state "none"*

3. Does any person listed in section A have a condition, disease or disorder not listed above? ☐ **Yes** ☐ **No**
(If yes, indicate details including name of person and type of disorder or treatment)

4. Does any person listed in section A have an outstanding medical referral, test or investigation pending? ☐ **Yes** ☐ **No**
(If yes, indicate details including name of person, reason for or type of investigation and anticipated date of completion)

5. Does any person listed in section A have abnormal test results for which additional medical consultation has been advised? ☐ **Yes** ☐ **No**
(If yes, indicate details including name of person and type of investigation or consultation)

6. Does any person listed in section A have undiagnosed signs and symptoms for which medical consultation is contemplated? ☐ **Yes** ☐ **No**
(If yes, indicate details including name of person and type of symptoms and signs)

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

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. Payment

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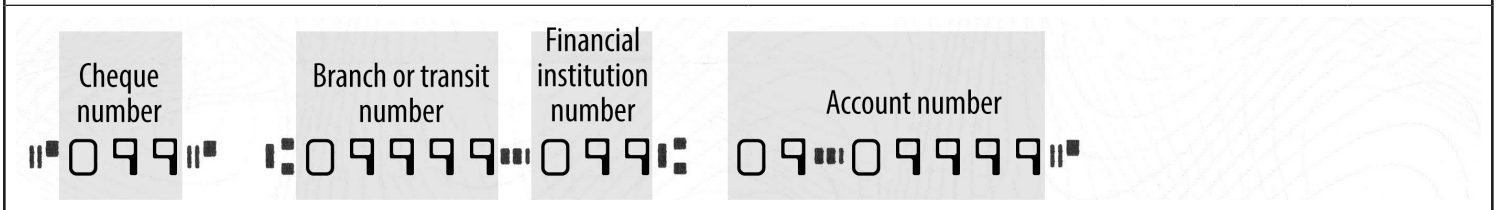
The applicant or account holder identified below (if different from the applicant) authorizes us to make the initial one-month withdrawal for the payment due on or after the date that this application is approved and for each month thereafter, from the account identified below. Withdrawals may be variable amounts as they may change in accordance with the agreement. **The account holder waives the right to receive further notice of the amount and date of each automatic withdrawal from the account.** This authorization may be terminated by written notice by either the account holder or us, in which we may terminate coverage or change the method of payment to another qualifying method. If the financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, we may attempt to withdraw the payment again on your next scheduled withdrawal date. The claims and treatment plan statement can be viewed online. You understand that if you or the account holder cancel the payment authorization, it may result in a loss of coverage unless we receive another form of payment.

Please complete the following banking information:



Three-digit cheque number (not required)	Five-digit branch or transit number	Three-digit financial institution number	12-digit (maximum) account number
☐	☐☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

If more than one signature is required on withdrawals issued against the account, both account holders must sign the authorization below.

All withdrawals from the account will be treated as personal withdrawals as defined in the Canadian Payments Association Rule H-1. We, or the account holder, may cancel this authorization at any time by giving 30 days' written notice. A copy of the cancellation form may be obtained by contacting the financial institution or through www.cdnpay.ca. The account holder has certain rights if any debit does not comply with this authorization. For example, the account holder has the right to receive reimbursement for a preauthorized withdrawal that is not authorized or is inconsistent with this authorization. To obtain a reimbursement claim, or for more information about recourse rights, contact the financial institution or visit www.cdnpay.ca.

Print name of account holder (payor)	Signature of account holder (payor)
Print second name (if joint account)	Second signature (if joint account)

Payor information (when payor is not the applicant or when payor is a business)

Last name	First name		
Address	City	Province	Postal code
Cell phone number	Home/alternative phone number	Primary email address	

E. Deposit information

You authorize us to deposit all amounts, including claim payments due to you into the account identified above. If you would like claims deposited into a different account than the one specified above, please indicate the account information below.

Three-digit cheque number (not required)	Five-digit branch or transit number	Three-digit financial institution number	12-digit (maximum) account number
☐	☐☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

Information statement

Health and Dental coverage is underwritten by Alberta Blue Cross

Accidental Death and Dismemberment and Term Life benefits are underwritten by Blue Cross Life Insurance Company of Canada.

F. Acknowledgment and consent *(please read, date and sign below)*

08

You hereby apply for the coverage identified on this application under the Blue Choice plan and acknowledge and agree to the following:

a. **Acceptance.** You acknowledge that you have read and understood all of the questions on this application and that the information contained herein is accurate and complete. You understand that if any information in this application is inaccurate, incomplete, false or misleading, or if you fail to disclose any material fact, we may void the agreement and any claim submitted shall not be due or payable by us.

Any injury or sickness, the signs of which first appeared on or before the date of this application, will not be covered by this agreement unless fully disclosed in this application.

If the applicant is not satisfied with the Blue Choice contract, they may terminate the agreement within 20 days of receipt and all payments will be refunded.

b. **Rejection.** In the event that this application is rejected, the applicant will be notified and all information relating to the application will be destroyed.

c. **Confirmation of coverage.** You acknowledge that this application is subject to our approval and the approval of Blue Cross Life Insurance Company of Canada and is not a contractual obligation. Coverage will not take effect until approved by us. If your application is approved, the effective date of coverage will be determined by us. We will confirm coverage within 30 days through the issuance to you of ID cards and provide you with a copy of the Blue Choice contract.

d. **Brochure.** The Blue Choice plan brochure is for marketing purposes only and does not form part of the agreement. The agreement consists of this application, the confirmation of coverage, exclusion agreement and the Blue Choice contract.

e. **Limitations and exclusions.** The coverage you are applying for is subject to limitations and exclusions. If we approve your application, you will be issued the Blue Choice contract setting out the definitions, limitations and exclusions. We recommend you read this carefully upon delivery.

f. **Electronic agreement.** If you apply for coverage by way of electronic agreement, such agreement shall be deemed to have been signed and delivered and to constitute "writing" for the purposes of any law requiring the agreement to be signed. Any electronic agreement that is entered into or accepted by you, or in your name or purported to be entered and accepted by you, will be considered to be binding on you.

g. **Cards.** You agree that the use of any card issued in connection with this agreement constitutes your agreement to the terms and conditions of such card, and the use of the card authorizes the use and exchange of personal information by us and our service providers with each other, pharmacies, health care providers, other insurers, administrators of government programs or other benefit programs and other organizations and service providers when necessary to assess and manage claims and administer benefits.

h. **Electronic communication.** You authorize us to correspond with you through the email address identified on this application. You understand that this is not guaranteed as a secured means of communication. You agree that should the email address on this application change, you are responsible for updating us. If you do not wish to receive emails from us, you may remove the email address by contacting our Individual Products Administration department at 1-800-394-1965.

i. **Travel benefit exclusions.** Travel benefits contain limitations and exclusions that could affect your coverage including a 90-day stability period prior to each eligible trip. This means that a claim that relates to a medical condition that has not been stable for 90 days prior to your date of departure will not be paid. It is important you read and understand your travel benefits for this and other exclusions that may affect your coverage.

G. Privacy notice

1. We recognize and respect the importance of privacy. Your personal information will be kept confidential and secure.
2. You authorize us and Blue Cross Life Insurance Company of Canada and our agents to collect, use, maintain and disclose personal information relevant to this application for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration, recommending suitable Alberta Blue Cross products and claim management.
3. You acknowledge and agree that your, or your spouse and dependants', personal information may only be collected from and released to a third party (health care professional, practitioner, or insurer or agent of record) only when needed for a purpose stated above.
4. You confirm you are authorized by your spouse and dependants to consent to this authorization on their behalf.
5. You understand that you can revoke this consent at any time in writing; however, if consent is withheld or revoked coverage may be denied or rescinded.
6. You understand why you have been asked to disclose this information and are aware of the risks and benefits of consenting or refusing to consent.
7. You agree that this consent shall be effective on the date of this application and shall be valid for the duration of the time coverage is in effect.
8. This consent complies with provincial and federal privacy legislation. For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to www.ab.bluecross.ca or email privacy compliance officer at privacy@ab.bluecross.ca.

Print name of applicant	Applicant signature	Print name of spouse	Spouse signature
Date 2 0 __ __ / __ __ / __ __ (Y Y M M D D)		**Date** 2 0 __ __ / __ __ / __ __ (Y Y M M D D)	

Agent's use only

Agent's name *(please print, if applicable)*	Company name	Agent's signature
Jennifer Kirby & Andrea Shandro	Vital Partners Inc.	

Mailing address	Email address	Phone number
#103, 138 18th Ave SE Calgary, AB T2G 5P(	jkirby@vitalpartnersinc.com	403.747.3288

ABC 55101 Blue Choice Application 2017/09

ALBERTA BLUE CROSS®

Blue CHOICE®

BLUE CHOICE PLAN RATE SHEET

Blue Choice® rate chart *(all dollar amounts are monthly fees for **each** family member)*

Extended health

Age	0-4	5-20*	21-34	35-44	45-54	55-64
Health - A	$6.30	$7.50	$9.60	$10.30	$12.50	$9.40
Health - B	$7.60	$11.50	$25.90	$26.70	$31.60	$31.40
Health - C	$10.20	$14.10	$34.80	$35.50	$44.10	$44.20

Dental

Age	0-4	5-20*	21-34	35-44	45-54	55-64
Dental - A	$4.60	$19.20	$28.90	$28.90	$29.70	$32.30
Dental - B	$4.90	$21.70	$36.50	$39.30	$41.10	$46.30
Dental - C	$7.80	$34.60	$64.00	$65.60	$71.50	$79.80

Drug

Age	0-4	5-20*	21-34	35-44	45-54	55-64
Drugs - A	$4.70	$6.00	$18.20	$21.20	$27.30	$37.00
Drugs - B	$5.60	$6.80	$20.30	$23.50	$29.70	$39.00
Drugs - C	$8.60	$10.90	$29.00	$33.90	$46.20	$59.70

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

Instructions

All individuals covered under the applicant's Alberta Health Care Insurance Plan account must be on the same Blue Choice plan.

1. Select your desired level of benefits.
2. Using the rate chart above, insert the rate for each family member into the rate calculation amount column.
3. Add the rates within each column to determine your total per benefit and combine for your grand total.

Rate calculator

	Extended health	Dental	Drug
Applicant			
Spouse			
Dependants			
Monthly rate	$ 0	$ 0	$ 0
Combined monthly total	$ 0		

**These rates are subject to change without notice.*