

UNIVERSAL INSURANCE APPLICATION

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NEW ENR	OLMENT	☐ CHANGE	□ REIN	NSTATEN	/IENT					
	-0.0	**************************************								
1 – PERSONA	AL INFORMAT	TION								
PRIMARY INSU	RED							1 8000		Sex
Last name							Languag	e choice		DM
First name				77			☐ French	□ En	glish	,DF
Date of birth	Day	Month Year	Age:	Place of	birth:					
Address	No.		Street				Apt.			
Piddies	City		Province			Postal co	ode			
Telephone	Home ()		Work ()		e-mail				
Marital Status	☐ Single	☐ Married ☐ D	ivorced 🗅	Widowed	☐ Common-law marriage					
Name of employer						Tel. ()			
Occupation (specif	y duties)					202010000	Accine			
Date of hiring (GLC	DBAL PLAN)				e-mail					
Annual salary or Net annual earning	s \$				GLOBAL PLAN (please com	plete this sectio	n only if	applying for	the GLOBA	AL PLAN
(After expenses and b					Do you contribute to :	employment	insuranc			
Are you: 🗓 a	n employee?	a company owner?	☐ self-employed?			WSI8?		□ Yes	□ No	
☐ Yes, I would like	to receive addition	al information on other Blu	e Cross products a	nd services.						
SPOUSE										Ser
Last name										ОΜ
First name										OF
Date of birth	Day	Month Year	Age:	Place of	birth:					
Telephone	Home ()				Work ()					
Name of employer	G-1					Tel. ()			
Occupation (specif							300			
Date of hiring (GL	OBAL PLAN)				e-mail					
Annual salary or Net annual earnin (After expenses and b	gs \$				GLOBAL PLAN (please com Do you contribute to :	nplete this secti				BAL PLA
		a company owner?	□ self-employed?			WSIB?		☐ Yes	s □ No	
☐ Yes, I would like	to receive addition	al information on other Blu	ue Cross products a	nd services.						
DEPENDENT CH	HILDREN			NO.		3 3 3 5		Date of birt	th	Ag
Last name	to the state of th	First name		Relationship	Relationship		Day	Month	Year	
		100,000,000,000			2	OM DE				
						OM OF				
		1				OM OF				
2 – POLICYH	OLDER - Prot	ection Primary In	sured (if diff	erent fro	m Primary Insured)		16	A A		W. I
POLICYHOLDER	Annual Contraction	eccion rimary in	sarea (ii aiii	CICITE III	in i i i i i i i i i i i i i i i i i i	Sex		Date of birt	h	Age
			Language choice			Day	Month	Year	1.35	
Last name	-					□ M □ F		33.53.67.2	0.000	_
First name	No		Street	□ Fre	ench 🗅 English					1
Address	100000	NOW IN THE PART OF				Apt.				
700000000	City Province Home () Work (ostal code mail			
Telephone										

Language choice

☐ English

☐ French

Province

Work (

NAME OF AGENCY

REPRESENTATIVE

CONTRACT NO.

NAME

Sex

Postal code e-mail

O F

Day

Date of birth

Month

Age

CODE NUMBER

010NT0145A (01-03)

POLICYHOLDER

No.

City

Home (

Last name

First name

Address

Telephone

3 – BENEFICIARY	PRIMARY INSURED	☐ Revocable	☐ Irrevocable	SPOUSE © Revocable © Irrevocable
Last name				Charles Land
First name				
Relationship				
Are you already insured under another Ontario Blue Cross [™] policy? ☐ Yes ☐ No If yes, please indicate the contract number:				

	DENTAL PLAN						
						Insured Amount	Monthly Premium
Disability d	lue to accident	Waiting	Period	Ber	nefit Period	\$	5
Primary	Coverage 1	□ 0 days	□ 30 days	□ 1 year	□ 5 years		
Insured		☐ 14 days	☐ 120 days	☐ 2 years	☐ to age 65		
9	Coverage 2	□ 0 days	☐ 30 days	□ 1 year	□ 5 years		
		☐ 14 days	☐ 120 days	☐ 2 years	☐ to age 65		
Spouse	Coverage 1	□ 0 days	☐ 30 days	□ 1 year	□ 5 years		
044-470047870	Activities and a second	☐ 14 days	☐ 120 days	☐ 2 years	☐ to age 65		
	Coverage 2	□ 0 days	☐ 30 days	☐ 1 year	□ 5 years		
		☐ 14 days	☐ 120 days	□ 2 years	☐ to age 65		
Disability d	lue to illness						
Primary Insured	Coverage 1	☐ 14 days	☐ 120 days	☐ 1 year	☐ 5 years		
maarca		□ 30 days	□ — days	☐ 2 years			
	 Coverage 2 	□ 14 days	☐ 120 days	□ 1 year	☐ 5 years		
		□ 30 days	□ — days	☐ 2 years			
Spouse	Coverage 1	☐ 14 days	☐ 120 days	☐ 1 year	□ 5 years		
	-	☐ 30 days	□ — days	☐ 2 years			
	Coverage 2	☐ 14 days ☐ 30 days	□ 120 days □ days	☐ 1 year ☐ 2 years	□ 5 years	,	
Overhead o	expenses						
Primary	Waiting period	0 days/accident	30 days/illness				
Insured	Benefit period	☐ 1 year	☐ 2 years				
Spouse	Waiting period Benefit period	0 days/accident ☐ 1 year	30 days/illness ☐ 2 years		19		
Accidental fracture		☐ Primary Insured	□ Single parent	☐ Family	□ Couple		
Medical exp	enses due to accident	☐ Primary Insured	□ Single parent	□ Family	□ Couple		
Hospital al	lowance	☐ Primary Insured	□ Single parent	☐ Family	□ Couple		
Accidental	death	☐ Primary Insured					
		□ Spouse					
Accidental	loss of use	☐ Primary Insured					
		□ Spouse					
Accidental d	leath & loss of use	☐ Dependent Children					
Critical illn	ess assistance	☐ Primary Insured	□ Nonsmoker	□Smoker			
		□ Spouse	□ Nonsmoker	☐ Smoker			
Post-accident adaptations		☐ Primary Insured	□ Single parent	□ Family	□ Couple		
	rance (including n and baggage)	☐ Primary Insured	□ Single parent	□ Family	□ Couple		
						Policy fee	\$2.25
					Total mo	nthly premium	
				Ann	ual premium = month	ly premium x 12	

5 – GLOBAL PLAN									
OCCUPATIONAL CATEGORIES		1746		No.					
Primary Insured	□ 2A □ 2A	□ 3A □ 3A	□ 4A □ 4A	□ B	Primary Insured Spouse		□ Nonsmoker □ Nonsmoker	□ Smoker □ Smoker	
COVERAGE SELECTED			Value of the second						
Disability		Waiting Perio	od	Bene Perio		Indexation	Insured Amount \$	Monthly Premium S	
Primary Coverage 1 Insured Non Taxable	☐ 14 days ☐ 14 M days	□ 30 days □ 30 M days	□ 60 days □ 90 days	□ 2 years □ 5 years		Unindexed Indexed			
Level premium option Coverage 2 Non Taxable Non Taxable	□ 14 days □ 14 M days	□ 30 days □ 30 M days	□ 120 days □ 60 days □ 90 days	☐ to age 65 ☐ 2 years ☐ 5 years ☐ to age 65		Unindexed Indexed			
Spouse Coverage 1 Non Taxable Taxable Taxable	□ 14 days □ 14 M days	□ 30 days □ 30 M days	□ 120 days □ 60 days □ 90 days □ 120 days	2 years	5 0	Unindexed Undexed			
Level premium option Coverage 2 Yes No Taxable Taxabl	□ 14 days □ 14 M days	□ 30 days □ 30 M days	□ 60 days □ 90 days □ 120 days	□ 2 years □ 5 years □ to age	5 0	Unindexed Indexed			
Life insurance	☐ Primary Insured☐ Spouse								
Accidental death & loss of use	□ Primary Insured				-				
2000 C 1035 O 1 45C	□ Spouse								
Life insurance, accidental death & loss of use	□ Dependent Children								
Overhead expenses	☐ Primary Insured	30-day waiting period	2-year benefit period						
	□ Spouse	30-day waiting period	2-year benefit period					. `	
Accidental fracture	☐ Primary Insured	□ Single parent	□ Family	Couple	2				
Extended health benefit including drugs	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
without drugs	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
Travel insurance (including cancellation and baggage)	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
Hospital allowance	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
Critical illness assistance	☐ Primary Insured								
	□ Spouse								
Home health care and assistance Basic	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
Deluxe	☐ Primary Insured	□ Single parent	□ Family	□ Couple					
Dental care	☐ Primary Insured	□ Single parent	□ Family	☐ Couple					
89	edical requirements ordered on :(Date)					Policy fee Total monthly premium			
Types of requirements requested :				Ann	ual prem	nium = montl	nly premium x 12		

Each of the individuals to b	oe insured hereby ag	AUTOMATIC BE rees to an automatic				ng protections:		
Primary Insured	Life insurance		☐ Accid	ental death an	nd loss of use	☐ Disability	19	
Spouse	□ Life insurance			ental death an	nd loss of use	☐ Disability		
Signed in:					Signature of	Primary Insured		
Date:					Fignatur	o of Coours		
					signatui	re of Spouse		
				2	Signatur	e of Witness		
6- EFFECTIVE INSURA	ANCE		W.			W. Carrier		
PRIMARY INSURED	3/2					W. S.		
DO YOU HAVE ANY OTHER INS	SURANCE POLICIES?	LIFE INSURANCE	□ YES		DISABILITY INSURAN	NCE D YES		
			□ NO			□NO		
LIFE INSURA	NCE				BILITY INSURANCE	5 6		
Company	Amount	Company		Monthly Benefits	Waiting Period	Benefit Period	Cancellable or Noncancellable	
SPOUSE				- VEG 15 15 1				
DO YOU HAVE ANY OTHER INS	SURANCE POLICIES?	LIFE INSURANCE	□ YES		DISABILITY INSURAI	NCE DYES		
			□NO			□ NO		
LIFE INSURA	NCE			DISAE	BILITY INSURANCE			
Company	Amount	Company		Monthly Benefits	Waiting Period	Benefit Period	Cancellable or Noncancellable	
I certify that this insurance	application replaces	stationers took the	or policies	J. 1888	of company, covera	ge and termination	date):	
I understand that the coverage statements, shall be null and vo Canassurance Life Insurance Cor	id if the coverage which	is to be replaced is main	ntained effec	tive. I also under	stand that the coverage	and/or partial coverage		
Signat	ure of Primary Insur	ed	70		Signat	ure of Spouse		
			Dat	e:				
Sig	gnature of Witness							
7 – DECLARATION	A SHUAL		-74	District St		Service Services		
Each of the people to be insured, complete. We, the people to be in otherwise be valid. Each of the people to be insured. This declaration offers no guaran and no changes in the insurability.	asks that Canassurance Late of insurance. The cor	any omission or fraudulen ife Insurance Company Ind stract takes effect on the o	t statement r :/Canassuran date of appro	nay result in cance ce Hospital Service wal of the applica	ellation of the insurance e Association issue a cont tion by the Insurer, provi	contract or rejection of tract as specified herein.	a claim that might	
Each of the people to be insured	acknowledges receipt of	the notice regarding the	Medical Infor	mation Bureau ar	nd exchange of informati	on.		
			-		Signature of I	Primary Insured	[7]	
Signed in:					Florida .	of Sanua		
20300			Signature of Spouse					
No representative is authorized to	actabilish as madify a C	www.com.	omnon-las	Canada manasa Nas		of Witness	s page to be invest	

^{*} No representative is authorized to establish or modify a Canassurance Life Insurance Company Inc./Canassurance Hospital Service Association contract, to determine if a person to be insured constitutes an acceptable risk or to waive any right or requirement in the name of Canassurance Life Insurance Company Inc./Canassurance Hospital Service Association.

AUTHORIZATION OF PRIMARY INSURED	
I hereby authorize any individual, corporate body, physician, healt Insurance Bureau (MIB) or any other organization, institution or p of that of my dependent children to release such information to C investigative consumer report about myself may be requested.	erson that has any records or knowledge of myself or my health, o
A photocopy of this authorization is as valid as the original.	
Date :	Signature of Primary Insured
	Signature of Witness
AUTHORIZATION OF SPOUSE	
I hereby authorize any individual or corporate body, physician, her Insurance Bureau (MIB) or any other organization, institution or p of that of my dependent children to release such information to C investigative consumer report about myself may be requested.	erson that has any records or knowledge of myself or my health, o
A photocopy of this authorization is as valid as the original.	
Date :	Signature of Spouse
	Signature of Witness

NOTICE REGARDING PERSONAL INFORMATION

Ontario Blue Cross aims to ensure you of 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:

185 The West Mall, Suite 600, Etobicoke ON M9C 5P1

INVESTIGATIVE CONSUMER REPORT AND EXCHANGE OF INFORMATION

Information regarding your insurability will be treated as confidential. The Insurer or the Insurer's reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, the Bureau, on request, will supply such company with the information about you in its files.

All insurers, including Canassurance Life Insurance Company Inc./Canassurance Hospital Service Association, sometimes write investigative consumer reports in applying standards on processing of applications. The report generally includes information on those to be insured and their life style. Upon request from you, the Medical Information Bureau will arrange to disclose to you the information in your file, except for medical information, which will be given only to your doctor. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and ask to have it corrected. The address of the Bureau's Information Office is as follows:

MEDICAL INFORMATION BUREAU, 330 UNIVERSITY AVENUE, SUITE 501, TORONTO, ONTARIO M5G 1R7
TELEPHONE: (416) 597-0590 / FAX: (416) 597-1193

AUTHORIZATION

AUTHORIZATION

NOTICE REGARDING CONSTITUTION OF A PERSONAL FILE

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

Ontario Blue Cross™ is committed to guaranteeing you the greatest possible confidentiality. All personal information about you will be kept in a file entitled "insurance file". The information we hold is confidential: access to your file is restricted to employees of the Insurer who must consult it in the course of their duties. In addition, barring objections from yourself, this information may be used for personalized solicitation by mail or telephone. You may consult your file and correct the information if need be by writing to us at Blue Cross, P.O. Box 4433, Station "A", Toronto ON M5W 3Y7

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