NEW ENROLLMENT or REINSTATEMENT

TTOC EXTENDEND HEALTH & DENTAL

BENEFITS CONTROL / WAIVER FORM

You must complete and return this form together with the applications.

This coversheet is used by the Payroll & Benefits Office to determine which coverage you want and any coverage that you choose to waive. Please make sure all applications are dated and signed**. If the attached applications are incomplete, they will be returned, and coverage may be delayed.** Please print clearly or use the fillable features.

Name: _____ Employee #: _____

Applications must be submitted within 31 days and not more than 4 months from your eligibility date. Please visit bcpseabenefits.ca/resources/faq/ to learn more about eligibility requirements. Benefit forms submitted after your effective date, but within the grace period, will be backdated and premiums will be adjusted accordingly.

Enrollment Checklist

Only check the boxes that apply to your situation and submit the corresponding pages.

☐ I have read the FAQ (Found at: https://www.sd61.bc.ca/payroll-and-benefits-gvta/)

☐ I understand that when I am not in receipt of pay, premiums will be collected via pre-authorized debit agreement and that benefits will be terminated after two failed attempts (NSF) to collect premiums *(PAD form completed and attached)*

BCPSEA Benefits with Pacific Blue Cross (Policy 20061) – *Complete and attach the BCPSEA Group Enrollment forms.*

Extended Health Care:

☐ Yes, I want EHC

☐ I am a LATE applicant for EHC *(PBC statement of health completed, signed, and attached).*
- I understand that PBC will determine the eligibility and effective date of EHC, and I may be declined.

☐ No, I do not want EHC *(Waiver of Coverage completed, signed, and attached)*

Dental:

☐ Yes, I want dental

☐ I am a LATE applicant for dental.
- I understand that there will be a dental expense restriction of $250 for the first 12 months of coverage for late applications.

☐ No, I do not want dental *(Waiver of Coverage completed, signed, and attached)*

I have been fully advised by the Greater Victoria School District of the benefit plans and options available to me for coverage under these plans. I understand the plans and options available to me, and I have applied, or waived coverage as described above.

Date: _____ Signature: _____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature (not typed, nor a handwritten font style)

The information collected on this form is required and will be used by School District No. 61 solely for purposes of benefit plan administration. It will be kept secure and confidential in accordance with the Freedom and Protection of Privacy Act. The information will also be used by the organizations that provide the benefits plans, as explained on the form that is used by the plan carrier. Any questions concerning the collection of use of this information by the School District may be addressed to: Payroll and Benefits Coordinator, Greater Victoria School District No. 61.

Please complete ·Pre-Authorized Debit (PAD) Plan Agreement Below

I/We authorize THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA), and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for regular monthly recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) Regular payments for the full amount of services delivered will be debited to my/our specified account **on the last pay of each month (Note: for May and June where it will be every pay to cover for summer months' benefits for Teachers, TTOCs, and ASAs)**. THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) has received written notification from me/us of its change or termination. This notification must be received at least (10) ten business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

THE BOARD OF EDUCATION SCHOOL DISTRICT 61 (GREATER VICTORIA) may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

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

Type of Service: Personal

Employee Number:_____

PLEASE PRINT **DATE:**_____

Name: _____

Address: _____

City/Town:_____ Province:_____ Postal Code:_____

Phone Number (Bus):_____ (Res):_____

Financial Institution {FI): AS ON FILE IN THE SCHOOL DISTRICT PAYROLL SYSTEM

Fl Account Number: N/A Fl Transit Number: N/A

Address: N/A

City/Town: N/A Province: N/A Postal Code: N/A

Employee Signature(s):. _____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature. (not typed, nor a handwritten font style)

The Board of Education School District 61 (Greater Victoria)
For all benefit inquiries, please contact Benefits Specialist
at the Payroll & Benefits Office: benefits@sd61.bc.ca

Only complete this form if you have a Common Law Spouse, this form is not applicable for married couples

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Please return completed form to your District Benefits Administrator.

Common Law Spouse Declaration

Employee Common Law Spouse Declaration

Employee's Last Name	First Name	Initial	District #

Common law spouse name: _____

Date co-habitation began: _____

Common law spouse definition: A person of the opposite or same sex, who has been residing with the Employee for a continuous period of at least 1 year, and is publicly represented as the Employee's spouse.

I hereby certify that my spouse meets the definition of common law spouse as defined above.

Employee Signature _____ Date Signed (mm/dd/yyyy) _____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature. (not typed, nor a handwritten font style)

This form is required for all new enrollments and reinstatements, including late applications.

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

The Group Enrolment Form complies with the requirements of the Insurers for the BCPSEA Benefits Buying Group Program and the information they require to underwrite and administer the benefit plans that are made available

Group Enrolment Form

Please return form to your District Benefits Administrator. **EMAIL THIS *SIGNED* FORM TO benefits@sd61.bc.ca.** **Administrators:** This form is to be completed on the date of hire or eligibility for new employees. Keep the original copy on file, as it will be required by the insurer if there is a future death or disability claim.

◉ New applicant ○ Reinstatement ☐ Late (If you are submitting your application more than 31 days, plus the 4 month grace period, from your eligibility date your application is late. **Late applications will require inclusion of the statement of health forms**)

Part 1: Employee and Basic Insurance Information

Employee's Last Name	First Name	Initial	ID Number[1]		Provincial Health Plan Number (Care Card)
Address	E-mail Address		Birth date (MM/DD/YYYY)	Gender ☐ M – Male ☐ F – Female ☐ X – Another Gender ☐ U – Prefer Not to Disclose	Marital Status ☐ Single ☐ Married * ☐ Separated ☐ Widowed ☐ Divorced ☐ Civil Union ☐ Common Law* *Date of Marriage or Cohabitation for Common Law (MM/DD/YYYY):

Required Health Coverage: ☐ Single ☐ Couple ☐ Family
Single-employee, Couple-employee plus one dependent, Family-employee plus two or more dependents

Required Dental Coverage: ☐ Single ☐ Couple ☐ Family
Single-employee, Couple-employee plus one dependent, Family-employee plus two or more dependents

If Extended Health or Dental are Waived, complete this form, and attach a Wavier of Coverage form.
The waiver is also required if you do not need EHC or dental for one or more of your dependents.

Dependents (Dependents include a spouse and/or children)

First Name	Initial	Last Name (if different from Employee)	Birth date (MM/DD/YYYY)	Relationship	Gender (M/F/X/U)	Required Coverage	Provide name of school and student number if child is over 21 and studying full-time. If child is disabled, indicate "disabled" in this section and attach the approved CRA/PWD (Persons with Disability) document. If adding an adopted child, provide date of adoption. If adding a legal ward, provide court document.
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	
						☐ Health ☐ Dental	

Part 2: Spousal or Other Coverage

Are you or your dependents covered for extended health and/or dental benefits by another
○ No ○ Yes (specify)

Employment type: ○ Full-time ○ Part-time ○ Retiree

Benefit	Name of Carrier/Policy #	Effective Date	ID Number	Coverage
Dental				○ Single ○ Couple ○ Family
Health				○ Single ○ Couple ○ Family

Part 3: Beneficiary Designation N/A FOR BCTF/GVTA

Complete the following section to appoint a beneficiary for any benefits payable on your death.

Beneficiary for Basic Life/Optional Life/Basic AD&D Insurance (if applicable) Last Name	First Name	Initial	Date of Birth (MM/DD/YY)	Share of Proceeds %	Relationship	Name of Trustee for Beneficiaries Under 18	Beneficiary Status[2]
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable
				%			☐ Revocable ☐ Irrevocable

Part 4: Personal Data Consent

Please see page 2 for further explanation

I consent to the collection, use, and disclosure of my personal information by my Plan Sponsor/Employer or the administrator, an insurance company, or any other person or organization having any relevant information about me (collectively "the Parties") who require this information for the purpose of administering my group benefits under the plan. I authorize the Parties to obtain and exchange between them, any personal information about me, my spouse, and my dependent children for the purpose of determining benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, administration of the plan and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to disclose their personal information to the Parties as required for the administration of the plan.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide the Insurance companies, when required by the latter, with all the information and authorizations required for the processing of any claim(s).

I hereby apply for group benefits under my Plan Sponsor's/Employer's plan and authorize any required deductions. I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor/Employer.

Employee Signature _____ Date Signed (MM/DD/YY) _____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature. (not typed, nor a handwritten font style)

Part 5: For Plan Administrator/Employer Use Only

Name of Employer / Organization	Employment Type	Division	Class[3]
Greater Victoria School District 61	☐ Full-time Permanent ☐ Part-time Permanent ☐ Temporary ☐ Retiree	11	11

Employee's Occupation/Position[4]	Annual Earnings	Eligibility Date: (MM/DD/YY)	Hours Worked Per Week[5]
	$ N/A		20

Dental		Extended Health		☐ Life ☐ AD&D (N/A for BCTF/GVTA - life provided by Manulife)		☐ STD ☐ LTD (N/A for BCTF/GVTA)	
Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)	Waiting Period	Effective (MM/DD/YY)

Please note that this Enrolment Form also serves for enrolling employees, of participating groups, on to the BCPVPA disability plans (LTD and STD, where applicable).

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[1] Please provide Employee ID/Payroll number. Please, do not use Social Insurance Number (SIN) as an employee ID.

[2] Beneficiary Status – The Beneficiary is considered revocable (can be changed in the future) unless otherwise stated. The Beneficiary can be made irrevocable, which means that if an employee wanted to change their beneficiary in the future they would require sign-off from the current beneficiary.

[3] If you have multiple classes under your plan, please indicate the class in which the employee should be enrolled.

[4] Employee's Occupation/Position: please choose from the following:

- Teacher
- Teacher Teaching On-call
- Principal/Vice-Principal
- Superintendent/Assistant Superintendent
- Secretary Treasurer/Assistant Secretary Treasurer
- Senior Manager/Director
- Non-Unionized Support Staff (please specify)*

**Non-Unionized Support Staff, e.g., Executive Assistants, Speech Therapist, etc.*

[5] Hours Worked Per Week – for BCPVPA a minimum of 17.5 hours per week is required to be eligible for LTD.

Only complete this form if you do not need/want EHC/Dental coverage.
If you want coverage later you may be considered a late applicant.

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Waiver of Coverage

Part 1: Employee Information

Employee's Last Name	First Name	Initial	District #	Employee ID#	Employee Group
					TTOC

Part 2: Waiver of Coverage

Before you sign this form, read the online benefit information available to you at www.bcpseabenefits.ca or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules before waiving your coverage.

Section A – Waiver certified by employer (Employer Signature Required)

I understand the benefits available to me under the BCPSEA Buying Group for my District and acknowledge that I have been given an opportunity to apply for these benefits, and

I do not want coverage for the following: ❑ Dental ❑ Extended Health benefits for:

❑ Myself and my dependents ❑ My dependents only

Employer – I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires employees/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Do NOT sign here

Employer Signature_____ Date Signed_____

Section B – Waiver due to coverage under another plan

☐ My dependents and I have benefits under another plan, as indicated in Part 3 of my BCPSEA Enrolment form. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to waive coverage under the BCPSEA Buying Group for:

❑ Myself and my dependents ❑ my dependents only for ❑ Dental; Policy Number#_____

❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health; Policy Number#_____

Termination Date:_____

If the other plan terminates, I understand that there are time limits for applying for coverage. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and the insurer may decline to cover me or my dependents.

Section C – Waiver due to leave of absence

☐ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the BCPSEA Buying Group for my district during this period of time for the following list of benefits:

Please list benefit coverage to be waived:

_____

Termination Date:_____

I understand that if I waive long term disability benefits (if applicable) during my leave and become disabled, the disability will not be covered by the plan and no benefits will be paid at any time. Coverage will not be reinstated until I return to active employment.

Part 3: Employee Signature

I have been offered the opportunity to participate in the BCPSEA Buying Group plan. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or that I will be required to prove, at my own expense, that I and my dependents are in good health. My insurer reserves the right to refuse my application if my health or my dependent's health is not considered satisfactory.

Employee Signature_____ Date Signed_____

Acceptable signatures include: 1) Print and sign in ink or 2) Save the form as a PDF and sign with a digitally drawn signature. (not typed, nor a handwritten font style)

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Complete this form if you are a late applicant

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | 604 419-2000 or Toll Free 1 877 PAC-BLUE | Fax: 604 419-2149

APPLICANTS — Please complete PART 2-7 of this application and return to enrollment@pac.bluecross.ca.
If applying for Optional Life coverage, please also complete a Beneficiary Designation form.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete PART 1 of this application.

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

DO NOT FILL IN PART 1 - THIS IS FOR THE EMPLOYER TO COMPLETE

Policy number	Name of company/organization	Member ID number	Date of hire/rehire (mm-dd-yyyy)
20061	Greater Victoria School Distrcit 61	000	

Reason for application: ■ Late enrollment ☐ Increase coverage ☐ Annual re-enrollment

Who is this application for: ☐ Member ☐ Spouse ☐ Dependent(s)

Type of insurance and amount applying for

- ☐ Life/Accidental death & dismemberment $ N/A
- ☐ Dependent life $ N/A
- ■ Extended health care
- ☐ Dental (N/A for SD61; Expense Limit of $250 for first 12 mo.)
- ☐ Short-term disability $ N/A
- ☐ Long-term disability $ N/A
- ☐ Critical illness $ N/A
- ☐ Member Optional Life $ N/A
- ☐ Spouse Optional Life $ N/A
- ☐ Member Optional Critical Illness $ N/A
- ☐ Spouse Optional Critical Illness $ N/A

PART 2 — APPLICANT INFORMATION

PUT YOUR INFORMATION HERE

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐F ☐M ☐U ☐X

Country of birth	Occupation	Height	Weight

Address	City	Province	Postal code

Email	Phone number	Fax

Physician and medical records

Please select one of the following and complete the details below accordingly

☐ Below is my primary physician's information ☐ I don't have a primary physician, but the clinic below has my records

Physician's first name	Physician's last name	Clinic name

Address	City	Province	Postal code

Email	Phone number	Fax

PART 3 — ADDITIONAL INDIVIDUALS TO BE COVERED

THIS IS WHERE YOU ADD YOUR SPOUSE AND/OR CHILDREN

Only fill out part 3 if there are additional individuals that you are applying for.

Spousal information

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Height	Weight

Dependent(s) information

Dependent 1

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐F ☐M ☐U ☐X

Dependent 2

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐F ☐M ☐U ☐X

Dependent 3

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐F ☐M ☐U ☐X

Dependent 4

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender* ☐F ☐M ☐U ☐X

*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

PART 4 — GENERAL DECLARATION

	MEMBER	SPOUSE
1. Have you or your spouse used any form of tobacco, tobacco cessation products, nicotine, e-cigarettes, or nicotine replacement products in the last 12 months? If yes, provide details (Member) _____ If yes, provide details (Spouse) _____	☐ Yes ☐ No	☐ Yes ☐ No
2. Has your weight decreased more than 4.5 kg or 10 lbs in the past year?	☐ Yes ☐ No	☐ Yes ☐ No

	If yes, how much weight was lost?	Reason(s) for weight loss
Member		
Spouse		

3. Have you or your dependents ever applied for or received benefits, compensation, or pension due to injury or disability? If yes, provide details. If yes, provide details (Member) _____ If yes, provide details (Spouse) _____	☐ Yes ☐ No	☐ Yes ☐ No

Dependents

Fill this out if this applies to 1 or more of your dependents. You do not need to identify which dependent.
☐ Yes ☐ No

If yes, provide details _____

PART 5 — MEDICAL DECLARATION

5.1 Have you, your spouse or dependent(s) consulted a physician, been treated for or have/had any known indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your doctor.

If you answer yes to any section in question 5.1 and/or 5.2, please complete question 5.4.

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
a) **Cardiovascular or circulatory** including vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke) and blood disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) **Diabetes / Endocrine disorders** including Type 1 or Type 2, hormonal or thyroid conditions.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) **Gastrointestinal conditions** including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), Colitis, Crohn's disease, Irritable Bowel Syndrome, Diverticulitis, Colon polyps, Ulcers, Hernia, GERD (acid reflux or persistent heartburn).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) **Respiratory or Lung conditions** including Allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) **Musculoskeletal conditions** including Osteoarthritis or Rheumatoid Arthritis, Osteoporosis, bone density loss or back, neck, limb or joint pain (including Fibromyalgia).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) **Immunological conditions** including being tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any other immunological disorder.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) **Genitourinary conditions** including kidney, bladder, infertility or Reproductive Disorders, Menopause, Endometriosis, Sexually Transmitted Disease(s) or recurring infections (cold sore/ Herpes/Shingles).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) **Neurological conditions** including Alzheimer's, Dementia, Parkinson's, epilepsy, Multiple Sclerosis, Seizures, Paralysis, chronic headaches or migraines, or Chronic Fatigue Syndrome.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) **Mental or Nervous conditions** including Anxiety, Depression, Emotional Disorders, Eating Disorders, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) **Cancer and Tumors** including malignant or benign, leukemia.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) **Drugs** including ever used narcotics, stimulants, hallucinogens or other drugs except those that were prescribed by a physician.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PART 5 — MEDICAL DECLARATION (continued)

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
5.2 Within the past five years, have you had any medical conditions not already mentioned on this form or abnormal test results?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.3 Do you currently have a referral, testing, treatment or investigation pending or contemplated but not yet completed, or are you aware of any symptoms or problems that require medical attention? If yes, provide details ______	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.4 If you answered YES to any part of question 5.1 and/or 5.2, please provide details. Please use one section per condition/disorder, even if an individual has multiple conditions/disorders.			

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

If there aren't enough sections in 5.4, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), conditions/disorders, diagnosis date, medication/treatment, and physician information.

______

______

5.5 Are you, your spouse or dependents taking any other prescribed medication(s) that you have NOT already disclosed above? If yes, provide name of medication(s) and reason below. Please use one section per individual, even if the individual is using multiple medications.

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

PART 5 — MEDICAL DECLARATION (continued)

If there aren't enough sections in 5.5, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), name of medication(s), dosage, frequency and reason(s) for medication.

5.6 Please identify any biological parents or siblings of yourself and/or your spouse who before the age 60, have ever had cancer, heart or kidney disease, mental or nervous disorder or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease).

INDIVIDUAL	DETAILS OF THE CONDITION
Member's parent 1	
Member's parent 2	
Member's sibling	
Member's sibling	
Spouse's parent 1	
Spouse's parent 2	
Spouse's sibling	
Spouse's sibling	

PART 6 — DECLARATION AND AUTHORIZATION

I, the undersigned, declare that the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Pacific Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me and to manage the company's business. For these purposes, I (i) authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, the MIB, LLC, or other organization, institute or person, that has any records or knowledge of me/my child or my/their health, to give Blue Cross Life, Pacific Blue Cross or their reinsurer any such information and (ii) Blue Cross Life and Pacific Blue Cross to access and use relevant information in records that they already hold about me.

I further authorize Blue Cross Life and Pacific Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/my child's personal physician or other medical practitioner. I have received and read the enclosed notice form describing the procedures of the MIB, LLC. I authorize Blue Cross Life and/or Pacific Blue Cross, or its reinsurer, to make a brief report of my personal health information to the MIB, LLC.

This consent is valid for as long as the contract is in force unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent. If I have questions about the collection, use or disclosure of my or my dependent's personal information, I can visit https://www.pac.bluecross.ca/privacy. A photocopy of this authorization shall be as valid as the original.

Member signature **X**	Date (mm-dd-yyyy)
Spouse signature **X**	Date (mm-dd-yyyy)

PART 7 — MIB, LLC PRE-NOTICE

IMPORTANT: Please read carefully.

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB, LLC member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, LLC. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, LLC.'s files, you may contact the MIB, LLC and seek a correction. The address of the MIB LLC's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Telephone: 1 866 692-6901. www.mib.com

Blue Cross Life Insurance Company of Canada or their reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.