

430-6800 NAME OF AGENCY  
*Biovail Pharmacy*

REPRESENTATIVE  
 NAME  
 CODE NUMBER

CONTRACT NO.

APPLICATION NO.  
**CO 17576**

# UNIVERSAL INSURANCE APPLICATION

NEW ENROLMENT     CHANGE     REINSTATEMENT

## 1 - PERSONAL INFORMATION

**PRIMARY INSURED**

Last name \_\_\_\_\_ Language choice \_\_\_\_\_ Sex  M  F  
 First name \_\_\_\_\_  French  English

Date of birth Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Address No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ e-mail \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Common-law marriage

Name of employer \_\_\_\_\_ Tel. ( ) \_\_\_\_\_  
 Occupation (specify duties) \_\_\_\_\_  
 Date of hiring (GLOBAL PLAN) \_\_\_\_\_ e-mail \_\_\_\_\_

Annual salary or Net annual earnings (After expenses and before taxes) \$ \_\_\_\_\_  
 Are you:  an employee?  a company owner?  self-employed?

**GLOBAL PLAN (please complete this section only if applying for the GLOBAL PLAN).**  
 Do you contribute to: employment insurance?  Yes  No  
 WSIB?  Yes  No

Yes, I would like to receive additional information on other Blue Cross products and services.

## SPOUSE

Last name \_\_\_\_\_ Sex  M  F  
 First name \_\_\_\_\_

Date of birth Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Name of employer \_\_\_\_\_ Tel. ( ) \_\_\_\_\_  
 Occupation (specify duties) \_\_\_\_\_  
 Date of hiring (GLOBAL PLAN) \_\_\_\_\_ e-mail \_\_\_\_\_

Annual salary or Net annual earnings (After expenses and before taxes) \$ \_\_\_\_\_  
 Are you:  an employee?  a company owner?  self-employed?

**GLOBAL PLAN (please complete this section only if applying for the GLOBAL PLAN).**  
 Do you contribute to: employment insurance?  Yes  No  
 WSIB?  Yes  No

Yes, I would like to receive additional information on other Blue Cross products and services.

DEPENDENT CHILDREN				Date of birth			Age
Last name	First name	Relationship	Sex	Day	Month	Year	
			<input type="checkbox"/> M <input type="checkbox"/> F				
			<input type="checkbox"/> M <input type="checkbox"/> F				
			<input type="checkbox"/> M <input type="checkbox"/> F				

## 2 - POLICYHOLDER - Protection Primary Insured (if different from Primary Insured)

**POLICYHOLDER**

Last name \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age \_\_\_\_\_  
 First name \_\_\_\_\_ Language choice  M  F  
 French  English

Address No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ e-mail \_\_\_\_\_

## - POLICYHOLDER - Protection Spouse (if different from Spouse)

**POLICYHOLDER**

Last name \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age \_\_\_\_\_  
 First name \_\_\_\_\_ Language choice  M  F  
 French  English

Address No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ e-mail \_\_\_\_\_

**3 – BENEFICIARY**
**PRIMARY INSURED**
 Revocable    Irrevocable

**SPOUSE**    Revocable    Irrevocable

Last name		
First name		
Relationship		
Are you already insured under another Ontario Blue Cross™ policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the contract number:		

**4 – ACCIDENTAL PLAN**
**COVERAGE SELECTED**

Disability due to accident		Waiting Period		Benefit Period		Insured Amount	Monthly Premium
						\$	\$
Primary Insured	Coverage 1	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years <input type="checkbox"/> to age 65		
	Coverage 2	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years <input type="checkbox"/> to age 65		
Spouse	Coverage 1	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years <input type="checkbox"/> to age 65		
	Coverage 2	<input type="checkbox"/> 0 days <input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years <input type="checkbox"/> to age 65		
<b>Disability due to illness</b>							
Primary Insured	Coverage 1	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days	<input type="checkbox"/> 120 days <input type="checkbox"/> _____ days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years		
	Coverage 2	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days	<input type="checkbox"/> 120 days <input type="checkbox"/> _____ days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years		
Spouse	Coverage 1	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days	<input type="checkbox"/> 120 days <input type="checkbox"/> _____ days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years		
	Coverage 2	<input type="checkbox"/> 14 days <input type="checkbox"/> 30 days	<input type="checkbox"/> 120 days <input type="checkbox"/> _____ days	<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years	<input type="checkbox"/> 5 years		
<b>Overhead expenses</b>							
Primary Insured	Waiting period	0 days/accident	30 days/illness				
	Benefit period	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years				
Spouse	Waiting period	0 days/accident	30 days/illness				
	Benefit period	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years				
<b>Accidental fracture</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
<b>Medical expenses due to accident</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
<b>Hospital allowance</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
<b>Accidental death</b>		<input type="checkbox"/> Primary Insured					
		<input type="checkbox"/> Spouse					
<b>Accidental loss of use</b>		<input type="checkbox"/> Primary Insured					
		<input type="checkbox"/> Spouse					
<b>Accidental death &amp; loss of use</b>		<input type="checkbox"/> Dependent Children					
<b>Critical illness assistance</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Nonsmoker	<input type="checkbox"/> Smoker			
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Nonsmoker	<input type="checkbox"/> Smoker			
<b>Post-accident adaptations</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
<b>Travel insurance (including cancellation and baggage)</b>		<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		

**Policy fee**
**\$2.25**
**Total monthly premium**
**Annual premium = monthly premium x 12**

**5 – GLOBAL PLAN**

**OCCUPATIONAL CATEGORIES**

Primary Insured  A  2A  3A  4A  B      Primary Insured  Nonsmoker  Smoker  
 Spouse  A  2A  3A  4A  B      Spouse  Nonsmoker  Smoker

**COVERAGE SELECTED**

Disability	Waiting Period	Benefit Period	Indexation	Insured Amount	Monthly Premium	
				\$	\$	
Primary Insured Coverage 1 Non Taxable <input type="checkbox"/> Taxable <input type="checkbox"/> Level premium option <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 14 days <input type="checkbox"/> 14 M days	<input type="checkbox"/> 30 days <input type="checkbox"/> 30 M days	<input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Unindexed <input type="checkbox"/> Indexed	
	<input type="checkbox"/> 14 days <input type="checkbox"/> 14 M days	<input type="checkbox"/> 30 days <input type="checkbox"/> 30 M days	<input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Unindexed <input type="checkbox"/> Indexed	
Spouse Coverage 1 Non Taxable <input type="checkbox"/> Taxable <input type="checkbox"/> Level premium option <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 14 days <input type="checkbox"/> 14 M days	<input type="checkbox"/> 30 days <input type="checkbox"/> 30 M days	<input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Unindexed <input type="checkbox"/> Indexed	
	<input type="checkbox"/> 14 days <input type="checkbox"/> 14 M days	<input type="checkbox"/> 30 days <input type="checkbox"/> 30 M days	<input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> to age 65	<input type="checkbox"/> Unindexed <input type="checkbox"/> Indexed	
Life insurance	<input type="checkbox"/> Primary Insured					
	<input type="checkbox"/> Spouse					
Accidental death & loss of use	<input type="checkbox"/> Primary Insured					
	<input type="checkbox"/> Spouse					
Life insurance, accidental death & loss of use	<input type="checkbox"/> Dependent Children					
Overhead expenses	<input type="checkbox"/> Primary Insured	30-day waiting period	2-year benefit period			
	<input type="checkbox"/> Spouse	30-day waiting period	2-year benefit period			
Accidental fracture	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
Extended health benefit including drugs	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
Travel insurance (including cancellation and baggage)	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
Hospital allowance	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
Critical illness assistance	<input type="checkbox"/> Primary Insured					
	<input type="checkbox"/> Spouse					
Home health care and assistance Basic	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		
Dental care	<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Single parent	<input type="checkbox"/> Family	<input type="checkbox"/> Couple		

Medical requirements ordered on : \_\_\_\_\_ (Date)  
 Firm : \_\_\_\_\_  
 Types of requirements requested : \_\_\_\_\_

Policy fee **\$1.00**  
 Total monthly premium \_\_\_\_\_  
 Annual premium = monthly premium x 12 \_\_\_\_\_

**AUTHORIZATION OF PRIMARY INSURED**

I hereby authorize any individual, corporate body, physician, health professional, hospital, clinic, insurance company, the Medical Insurance Bureau (MIB) or any other organization, institution or person that has any records or knowledge of myself or my health, or of that of my dependent children to release such information to Ontario Blue Cross™ or its reinsurers. I also agree that an investigative consumer report about myself may be requested.

A photocopy of this authorization is as valid as the original.

Date : \_\_\_\_\_

\_\_\_\_\_  
Signature of Primary Insured

**CO 17576**

\_\_\_\_\_  
Signature of Witness

**AUTHORIZATION OF SPOUSE**

I hereby authorize any individual or corporate body, physician, health professional, hospital, clinic, insurance company, the Medical Insurance Bureau (MIB) or any other organization, institution or person that has any records or knowledge of myself or my health, or of that of my dependent children to release such information to Ontario Blue Cross™ or its reinsurers. I also agree that an investigative consumer report about myself may be requested.

A photocopy of this authorization is as valid as the original.

Date : \_\_\_\_\_

\_\_\_\_\_  
Signature of Spouse

**CO 17576**

\_\_\_\_\_  
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

**CO 17576**

**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

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# AUTHORIZATION

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## 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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