

7 - TO BE COMPLETED FOR CRITICAL ILLNESS ASSISTANCE BENEFIT ONLY

I, the undersigned, hereby declare that a critical illness contract covering at least the five illnesses covered by Global Plan and for an amount of insurance of at least \$25 000 has been issued by another insurer for the person to be insured within the 60 days preceding the signing of this application.

	Name of company issuing the contract	Contract no. and effective date
Primary Insured		
Spouse		

Signed in _____, this _____ day of _____,

Signature of Primary Insured (Policyholder if Primary Insured is under age 18) _____ Signature of Spouse _____ Signature of Representative _____

DECLARATION FOR CRITICAL ILLNESS ASSISTANCE BENEFIT

Each person to be insured hereby declares that he/she has never consulted a doctor, been hospitalized, taken drugs or received treatment for any of the following conditions:

- a) Cardiovascular disorders (heart attack, angina, arrhythmia, pacemaker, defibrillator, hypertension, heart failure, bypass, angioplasty, valvulopathy or valve replacement, aortic aneurysm, heart transplant, peripheral vascular disease or any other heart surgery)
- b) Chronic obstructive pulmonary disorders (asthma, emphysema, chronic bronchitis, lung transplant)
- c) Neurological disorders (stroke, transient cerebral ischemia (TCI))
- d) Insulin-dependent diabetes (diabetes treated with injected insulin)
- e) Kidney failure, kidney transplant
- f) Gastrointestinal disorders (cirrhosis, hepatitis, ulcer, internal bleeding, liver transplant, surgery for bowel obstruction)
- g) Cancer or malignant tumour

Signed in _____, this _____ day of _____,

Signature of Primary Insured (Policyholder if Primary Insured is under age 18) _____ Signature of Spouse _____ Signature of Representative _____

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE PROVIDE DETAILS BELOW.

QUESTION NO.	PERSON'S FIRST NAME	DETAILS OF DIAGNOSIS AND TREATMENT	DATE OF EACH OCCURRENCE	SYMPTOM DURATION	DURATION OF ABSENCE FROM WORK	NAMES AND ADDRESSES OF DOCTORS AND MEDICAL ESTABLISHMENTS

8 - METHOD OF PAYMENT

MONTHLY CREDIT CARD PAYMENT Amex MasterCard VISA

Expiration date _____

Card no. _____ Month _____ Year _____ Signature of Cardholder _____

MONTHLY DIRECT DEBIT: Please sign the following authorization and attach a void cheque.

AUTHORIZATION: I authorize the Insurer to make monthly withdrawals from my account, the number of which is shown on the attached void cheque.

Desired date for withdrawing monthly premium (except the 29th, 30th or 31st of the month) _____

Signature of account holder(s) _____

(In case of a joint account, all account holders must sign)

ANNUAL PAYMENT: Please attach a cheque payable to **ONTARIO BLUE CROSS™**

Payment received A cheque in the amount of \$ _____ to cover the first premium accompanies the application.

Would you like a receipt for income tax purposes? Yes No

9 - DECLARATIONS

Each of the people to be insured hereby declares that all answers and explanations given in this declaration of health and in any other document which, by agreement, forms a part thereof are true and complete. We, the people to be insured, understand that any omission or fraudulent statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid. We also understand that any injury on the date of this application or prior to it, or any illness for which signs appeared on the date of this application or before are not covered, unless completely disclosed in this declaration of health.

Each of the people to be insured asks that Canassurance Life Insurance Company Inc./Canassurance Hospital Service Association issue a contract as specified herein.

This declaration offers no guarantee of insurance. The contract takes effect on the date of its approval by the Insurer, provided the first premium has been paid in full and no changes in the insurability of the people to be insured have occurred since the signing of the application.

Each person to be insured acknowledges receipt of the notice regarding the Medical Information Bureau and exchange of information.

Signed in _____ Signature of Primary Insured _____

_____ Signature of Spouse _____

Date _____ Signature of Witness _____

* 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 rights or requirements in the name of Canassurance Life Insurance Company Inc./Canassurance Hospital Service Association.