

PART II - MEDICAL INFORMATION

Please take the time to read carefully and answer the following questions. Should our post-audit process determine that the responses to these questions did not represent complete and full disclosure, this policy could be cancelled without advance notification.

1. Are you and all listed dependents currently covered by a Provincial Health Plan within Atlantic Canada (Medicare in New Brunswick, Medical Services Insurance in Nova Scotia, Hospital and Medical Services Ins. in Prince Edward Island or Medical Care Plan in Newfoundland)? Yes No

If no, please explain _____

2. Have you or any listed dependent ever consulted a physician, been treated for or had any indication of:

- | | |
|---|--|
| A. Chest pain, heart or circulatory trouble or irregular heart rate (fast or slow) <input type="checkbox"/> Yes <input type="checkbox"/> No | H. Bone, muscle or joint disorder / arthritis / osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. High blood pressure, stroke, blood disorder or elevated cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | I. Depression or anxiety disorder, nervous breakdown, mental illness, insomnia or other sleep disorder (i.e. sleep apnea) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Cancer, tumor (benign / malignant) or leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | J. Respiratory disorder, asthma or allergies <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. Diabetes / elevated sugar levels, colitis or Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | K. Disease or disorder of the reproductive system or infertility <input type="checkbox"/> Yes <input type="checkbox"/> No |
| E. AIDS, ARC (Aids Related Complex) or other immunological disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | L. Erectile dysfunction / impotency <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F. Alcohol or drug dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | M. Chronic headaches/migraines or recurrent infection <input type="checkbox"/> Yes <input type="checkbox"/> No |
| G. Stomach, intestinal, liver, kidney or bladder disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | N. Acne, rosacea or skin disease / disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | O. Brain or neurological disorder, epilepsy, convulsion, loss of consciousness or multiple sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered "yes" to any of the above questions, please give details below:

Person's Name	Condition	Date First Treated	Duration of Treatment	Type of Treatment	Results of Treatment / Extent of Recovery

3. Do you or any listed dependent currently take any prescription medication or have a prescription for which refills are currently authorized - including Hormone Replacement Therapy for any reason (i.e. menopausal treatment), sedatives, etc.? (Please consider all forms of medication, i.e., oral, serums, injections, drops, creams and suppositories.) Yes No If you answered "yes", please give details:

Person's Name	Prescription Name	Strength	Quantity Taken	Cost/Month	Reason

4. Within the past 2 years, have you or any listed dependent:

- | | |
|--|---|
| a) received treatment from a chiropractor, podiatrist, physiotherapist or psychologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | c) required orthopedic shoes, orthopedic supplies or arch supports? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) used any ostomy supplies, diabetic supplies, maximit, CPAP or TENS machine? <input type="checkbox"/> Yes <input type="checkbox"/> No | d) required ambulance services or nursing care? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | e) required artificial limbs / prosthesis, braces, walker, wheelchair or oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered "yes", to any of these questions, please give details below:

Person's Name	Type & Number of Treatments	Date First Treated	Date Last Treated	Reason for Treatment	Results of Treatment/ Extent of Recovery

5. Do you, or any listed dependent, currently have a referral, testing, treatment, investigation, surgery or appointment contemplated or completed but for which the results have not yet been received? Yes No

If answer is "yes", please give details: _____

6. Have you or any listed dependent smoked tobacco or used tobacco or nicotine in any form (including nicotine replacement products and/or smoking cessation products) in the last 12 months? Yes No

If "yes", please indicate person's name(s): _____

7. Are you or any of your listed dependents pregnant? Yes No If "yes", please indicate person's name and due date: _____

Please note that maternity benefits or conditions arising out of pregnancy are available only after eight (8) months continuous coverage.

8. Within the last 3 years have you or any listed dependent been hospitalized? Yes No
If "yes", please explain the following: Who? Date? Duration? Reason? Name of physician? Result?

9. During the past 3 years, have you or any listed dependent had your driver's license suspended or revoked, been convicted of a) more than 3 driving violations? b) refusing to take a breathalyser? or c) driving while impaired? Yes No If "yes", please give details.

10. In the past 5 years, have you or any listed dependent ever used narcotics (e.g. morphine, heroin), controlled substances (e.g. diazepam, lorazepam), hallucinogens (e.g. LSD, marijuana) or stimulants (e.g. amphetamines, cocaine), except as prescribed by a physician? Yes No If "yes", please provide details including type, usual quantity and frequency of use, and date of last usage.

11. Do you or any listed dependent have a physical impairment, disease or disorder not stated above? Yes No If "yes", please give details.

AGREEMENT AND CONSENT

I/We, the undersigned, understand and agree that any pre-existing condition/injury or the signs of which that appeared or occurred on or before the date of this application are not covered by this policy. The discovery of facts known by my/our eligible dependents or me/us but not stated on this application could result in the denial of a claim and the cancellation or modification of this policy. I/We further acknowledge that it is my/our responsibility to notify Atlantic Blue Cross Care of any changes in my/our health status or the health of my/our dependents from the date of application until a policy is issued or the effective date, whichever is later. Atlantic Blue Cross Care reserves the right to recover any monies paid on my/our behalf or on the behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this application form. I/We agree to repay to Atlantic Blue Cross Care any and all monies paid as a result of the discovery of facts not fully disclosed on this application.

I, the undersigned, declare the answers to the above questions 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 Atlantic Blue Cross Care. 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. I authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of me or my health, to give Blue Cross Life, Atlantic Blue Cross Care or their reinsurer any such information. I further authorize Blue Cross Life and Atlantic Blue Cross Care 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 personal physician or other medical practitioner. 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. I have received and read the attached notice form describing the procedures of the Medical Information Bureau. I can contact Atlantic Blue Cross Care at 1-800-667-4511 should I have questions as to the collection, use or disclosure of my personal information.

This consent complies with federal and provincial privacy laws.

(A photographic copy of this authorization shall be as valid as the original.)

Dated on this _____ day of _____ year _____

Signature of Applicant _____ Signature of Spouse / Cohabitant _____
(as defined in policy)

* not applicable in Ontario or Quebec.

Premium Receipt

Please detach and give to applicant

Atlantic Blue Cross Care acknowledges receipt of \$ _____ paid in connection with the application for Personal Health Coverage. This receipt acknowledges that the sum referred to above has been received on behalf of Atlantic Blue Cross Care and NO COVERAGE EITHER EXPRESSED OR IMPLIED is conveyed by the acceptance of such sum. The applicant hereby acknowledges and agrees that THERE IS NO HEALTH COVERAGE resulting from the acceptance of the money and that Atlantic Blue Cross Care is not at risk unless a contract comes into effect as a result of this application.

Notice of the Medical Information Bureau

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or their reinsurer may make a brief report thereon to the Medical Information Bureau, a non-profit 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 insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7.

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

QUOTATION WORK SHEET

	<i>OPTIONS PLUS</i> Monthly Rate		<i>OPTIONS</i> Monthly Rate
Mandatory - Principal Benefits Module _____			Mandatory - Principal Benefits Module _____
Optional - Drug Module _____			Optional - Drug Module _____
- Dental Module _____			- Dental Module _____
- Critical Care Module _____			- Critical Care Module _____
			- Hospital Cash Plan Module _____
Monthly Total	<input style="width: 80px; height: 20px;" type="text"/>		Monthly Total
<p><i>These rates are subject to approval based on satisfactory evidence of health. Rates are subject to change between the date of application and the policy effective date.</i></p>			

I hereby certify that, as an agent for Atlantic Blue Cross Care, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Atlantic Blue Cross Care the right to cancel the contract of insurance and refuse coverage under the policy.

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Agent's Signature	Agent's Number	Agent's Telephone Number
Daniel MacLellan		9 0 2 ▲ 8 9 3 ▲ 6 1 2 6
Agent's Name (please print)		Agent's Fax Number
105 Walker St., Truro, Nova Scotia, B2N 4B1		
Agent's Mailing Address		
DMacLellan@mmfi.ca		
Agent's e-mail Address		
Agent Comments _____		

AGENT



TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied.

Accidental death and dismemberment benefits, Life Benefits and Critical Care will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Atlantic Blue Cross Care.