INSTRUCTIONS:

1. Print in ink, or type information.
2. Complete all parts of the application, including all questions & details.
3. Missing information will delay the processing of your application.
4. Remember to sign and date your application.
5. Original application required.

PLEASE FORWARD TO YOUR INSURANCE BROKER

Long-term Care Application Form

# HOSPITALIZATION & LOSS OF AUTONOMY BENEFIT

**Plan 1:** Long-term care services, supplies & equipment

## 1. COVERAGE SELECTION – *You Must Have OHIP Coverage to Apply*

| Select Coverage: ☐ $50,000 - Hospitalization & Loss of Autonomy Benefit (Long-term care services, supplies & equipment) | Premium |
|---|---|
| Annual Premium - Subtotal | $ |
| Policy Fee* | $ |
| Total Annual Premium | $ |
| Monthly Premium = Annual Premium x 0.09 | $ |

* If several family members subscribe to a Tangible contract on the same date, a 25% rebate on the policy fees will be applicable for the 2nd and following insureds. Please apply the 25% rebate on the policy fee for the following people:

| Family Member's Name | Application No. | Relationship |
|---|---|---|
| | | |

| Family Member's Name | Application No. | Relationship |
|---|---|---|
| | | |

In the case of a child born after the effective date of the Tangible contract, the same rebate will be applicable, if the child subscribes during the first year of birth.

## 2. PERSONAL INFORMATION – *Primary Insured*

| | Language | Sex | Date of Birth | | | |
|---|---|---|---|---|---|---|
| Last Name | ☐ French | ☐ M | Day [dd] | Month [mm] | Year [yyyy] | Age |
| First Name | ☐ English | ☐ F | | | | |

Civil Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common-law ☐ Non-smoker ☐ Smoker

If you are not a Canadian citizen, please indicate if you are: ☐ Permanent Resident [Landed immigrant] ☐ Other [Please specify]: ____________

| Address | No. | Street | Apt. |
|---|---|---|---|
| | City | Province | Postal Code |
| Telephone | Home | Cell | |
| E-mail | | | |

## 3. POLICYHOLDER INFORMATION – *(if different from Primary Insured)*

| | Language | Sex | Date of Birth | | | |
|---|---|---|---|---|---|---|
| Last Name | ☐ French | ☐ M | Day [dd] | Month [mm] | Year [yyyy] | Age |
| First Name | ☐ English | ☐ F | | | | |

| Address | No. | Street | Apt. |
|---|---|---|---|
| | City | Province | Postal Code |
| Telephone | Home | Work | |
| E-mail | | | |

**Primary Insured** *(Please Print)*

Last Name

First Name

Long-term Care Application Form

**HOSPITALIZATION & LOSS OF AUTONOMY BENEFIT**

**Plan 1:** Long-term care services, supplies & equipment



## 4. METHOD OF PAYMENT

☐ CREDIT CARD PAYMENT: ☐ MONTHLY ☐ ANNUAL ☐ AMEX ☐ MasterCard ☐ VISA

Card No. Expiration Date Signature of Card Holder

☐ MONTHLY DIRECT DEBIT: Please sign the pre-authorized debit (PAD) agreement and attach a void cheque.
Would you like your first premium to be debited directly from your account? ☐ Yes ☐ No If no, please attach a cheque for the first premium amount.

☐ ANNUAL CHEQUE: Please attach a cheque payable to ONTARIO BLUE CROSS

☐ Payment Received | A cheque in the amount of $ ____________ representing the first premium payment is attached herewith.

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

## 5. EFFECTIVE INSURANCE OR APPLICATION UNDER REVIEW

If you already have an Ontario Blue Cross policy, please indicate the contract number:

Do you have a long-term care policy or an application under review, including through your employer? ☐ Yes ☐ No
If yes, please complete the following information:

| Company | Type of Long-term Care Contract | Effective Date | Amount | Waiting Period | Benefit Period |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

If this application is to replace an existing policy or policies, please list the policy or policies below (specifying the name of the company, the coverage and the termination date): ____________

# PRELIMINARY QUESTIONNAIRE

| PERSONAL INFORMATION – *Primary Insured* | Application Number | | | | |
|---|---|---|---|---|---|
| | Sex | Date of Birth | | | |
| Last Name | ☐ M | Day [dd] | Month [mm] | Year [yyyy] | Age |
| First Name | ☐ F | | | | |

## DECLARATION

To be eligible for the Hospitalization and Loss of Autonomy benefit, you must answer **NO** to all of the questions in this section. If you answer yes to any of the questions below, you are not eligible to apply for these benefits.

Each person to be insured hereby declares the following:

| Do you have or have you ever had any of the following conditions or symptoms? | Yes | No |
|---|---|---|
| AIDS, HIV positive, AIDS-related complex (ARC)? | | |
| Insulin-dependent diabetes? | | |
| Alzheimer's disease, Parkinson's disease, Huntington's chorea, memory loss, dementia, senility, cerebral palsy or brain disease or disorder? | | |
| Multiple sclerosis, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease/Charcot's disease) or muscular dystrophy? | | |
| Liver cirrhosis, hepatitis C, active hepatitis B or major organ transplant? | | |
| Paralysis, stroke (two episodes or more) or transient ischemic attack (two episodes or more)? | | |
| Amputation due to disease? | | |
| Bladder or bowel incontinence, long-term disability or disability recognized by the CPP or by provincial authorities? | | |
| Osteoporosis with fractures, lupus other than discoid lupus erythematosus? | | |
| Cystic fibrosis, pulmonary fibrosis? | | |
| Sickle cell anemia, leukemia? | | |
| Alcohol or drug abuse during the last 3 years? | | |
| Nervous system: depression supported by a clinical diagnosis **actively** treated for more than 1 (one) year, anorexia, attention deficit disorder or any other clinically diagnosed mental disorder? | | |

| At the present time... | Yes | No |
|---|---|---|
| Do you use a cane, a walker, a wheelchair or an oxygen device? | | |
| Are you waiting for surgery? | | |
| Are you undergoing renal dialysis? | | |
| Are you suffering from dizziness for which a diagnosis has not been made yet? | | |

| During your lifetime... | Yes | No |
|---|---|---|
| Have you ever attempted to commit suicide? | | |

**Primary Insured** *(Please Print)*

Last Name

First Name

Long-term Care Application Form

# HOSPITALIZATION & LOSS OF AUTONOMY BENEFIT

**Plan 1:** Long-term care services, supplies & equipment



## 6. DECLARATION

- Each person to be insured, hereby declares that he/she is a beneficiary in the meaning of the health and hospital insurance legislation in his/her province of residence.
- Each person to be insured, hereby declares that all answers given in this application and in any other document which, by agreement forms a part thereof are true and complete. We, the persons to be insured, understand that any omission or misrepresentation statement may result in cancellation of the insurance contract or rejection of a claim that might otherwise be valid.
- The Primary Insured asks that Canassurance Insurance Company issue a contract as specified herein.
- This declaration offers no guarantee of insurance.
- The Primary Insured acknowledges receipt of the "Notice regarding personal information".

Signed in [City] ______________ this [Day] ______________ day of [Month, Year] ______________

Signature of the person to be insured

Signature of Representative

Note: No representative is authorized to establish or modify a Canassurance Insurance Company 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 Insurance Company.

For Agent Use Only

| Agent Name | Agent No. | Telephone | Fax | Agent Signature |
|---|---|---|---|---|
| | | | | |

For Ontario Blue Cross Use Only

| Identification No. | Underwriting Approval Signature | Date |
|---|---|---|
| | | |

## NOTICE REGARDING PERSONAL INFORMATION

By applying for our insurance product(s), you are consenting to our collecting, using and disclosing your personal information for the purposes of appraising your insurance application, confirming your coverage and/or benefits, processing or paying your claims.

Your insurance file will be maintained on a confidential basis at our offices. Your personal information will only be accessible by our employees and authorized representatives who need access to your file for the purposes set out above.

Upon written notice, you will be entitled to access the personal information contained in your file and, if applicable, request that your file be updated or corrected.

For additional information regarding the manner in which we collect, use, disclose and otherwise manage your personal information, please visit our Web site **www.useblue.com** or write to us at: **Chief Privacy Officer**
Canassurance Insurance Company
185 The West Mall, Suite 610, Etobicoke, Ontario M9C 5P1
privacyofficer@ont.bluecross.ca

**TO BE GIVEN TO THE PERSON TO BE INSURED (PRIMARY INSURED)**

| ***Primary Insured*** ***(Please Print)*** | FOR ADMINISTRATION ONLY |
|---|---|
| Last Name | |
| First Name | Contract No. |

# Pre-authorized Debit (PAD) Agreement



## 1. PAYOR INFORMATION – *Last and first names of depositors (please print)*

| | | | | |
|---|---|---|---|---|
| Account Holder Last Name | | | First Name | |
| Joint Account Holder Last Name | | | First Name | |
| Address | No. | Street | | Apt. |
| | City | | Province | Postal Code |
| Telephone | Home | | Cell | |
| E-mail | | | | |

## 2. BANK ACCOUNT INFORMATION – *Type of Service: Personal*

| | | | | |
|---|---|---|---|---|
| Financial Institution | | | | |
| Address | No. | Street | | Suite |
| | City | | Province | Postal Code |
| Institution No. | Branch Transit No. | | Account No. | |

## 3. AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1. I, the undersigned, hereby authorize Canassurance Insurance Company, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $__________, in payment of my insurance contract. If no date is entered, I understand that the date may be determined by the Insurer without giving me prior notice.

   **Desired withdrawal date: ________________ (excluding the 29th, 30th and 31st).**
   **I have attached a sample cheque** ☐

   I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing in respect of my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all pre-authorized debits (PAD) withdrawn from my account are fixed or variable-amount personal PADs.
2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to send me prior notice of thirty (30) days only for the renewal of my policy.
3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution. I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.
4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten (10) business days prior to a PAD.
5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service department at 1-866-722-3444. **I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD.**
6. I understand that I may revoke this authorization at any time subject to providing ten (10) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit **www.cdnpay.ca**.
7. I understand that the Insurer may cancel this Agreement upon thirty (30) days written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.
8. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

## 4. SIGNATURE

| | |
|---|---|
| Signature of the account holder | Signature of joint account holder (if applicable) |
| Name (please print) | Name (please print) |
| Date [dd/mm/yyyy] | Date [dd/mm/yyyy] |