

elements

EASY STEPS to immediate coverage!

We make the process easy to get comprehensive Drug & Health Insurance for you and your family.





Fill out and sign the application

Questions about the coverage? Please contact one of our authorized Blue Cross agent directly at **1.888.506.1125**. We will assist you in the application process or to obtain more information about your options. **Send** the application

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Email bluecross@optimalquotes.ca

Fax 1 (888) 450 4950

Mail 425 Notre-Dame St., Dieppe NB E1A 9G4

CENTRE FINANCIER OPTIMAL



APPLICATION FOR GUARANTEED ISSUE HEALTH PLAN

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 230 BROWNLOW AVE DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6 FOR ALL INQUIRIES: **1-800-667-4511**

Please print in ink or type information.

			Fiedse		
APPLICANT'S PERSONAL INFORMAT	ΓΙΟΝ				
Applicant's Last Name (Applicant must be age 16 o	licant's Last Name (Applicant must be age 16 or older): First Name:				
Language Preference: OEnglish OFr	ench Occupation:				
E-mail address:					
Address (Street & No.):			5		
City/Town:	Province:		Postal (Code:	
Telephone No.:				- MOBILE	
How would you like us to contact you?	E-mail OMail How would you like to	receive	your policy booklet? 🔘	-	Print
Requested Effective Date of Policy: Please	begin my coverage on the 1 st day of (mont	h/year):			
Is this application intended to replace your o	current Medavie Blue Cross policy? (Yes	O No		
ID Number:	Policy N	umber:			
First Name	Last Name	Sex M/F	Date of Birth DD MM YY	Please (✓) if you or your dependents DO NOT wish Drug coverage	Full-Time Student
Applicant	00				
Spouse**	01				
Child	02				
Child	03				
Child	04				
	05				
Spouse shall mean an individual who is marrie	d to the applicant or resides at the same address	as the a	pplicant.		
AGREEMENT					
I, the undersigned, hereby apply for the ben Guaranteed Issue Health Plan policy. I confi				oss, as outlined i	n the
I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Medavie Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.					
l understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Medavie Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.					
Your personal information will be securely stored using information systems owned or managed by Medavie Blue Cross, its agents and/or its service providers, both inside and outside of Canada. All service providers and agents are contractually bound to protect the confidentiality of all personal information.					
I authorize Medavie Blue Cross to collect, u	se and disclose my personal information as	s descril	bed above.		
Dated on this	day of		year		

Signature of Applicant _

Signature of Spouse / Cohabitant -(as defined in policy)

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding Medavie Blue Cross's privacy policies, visit <u>www.medavie.bluecross.ca</u> or call 1-800-667-4511.

FOR MEDAVIE BLUE CROSS USE ONLY					
I.D. No.:	CASH OFFICE:	Amount Received:	Agent	Branch	Client
					FORM-434E 01/1

PLEASE COMPLETE THE PRE-AUTHORIZED	DEBIT (PAD) PLAN AGREEMENT BELOW.				
I/We authorize Medavie Blue Cross, 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 recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited from my/our specified account on the first business day of every month. Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.					
notification must be received at least 30 business of	Blue Cross has received written notification from me/us of its change or termination. This days before the next debit is scheduled. This notification must be sent to the Administration tain a sample cancellation form or more information on my/our right to cancel a PAD iting www.cdnpay.ca.				
reimbursement for any PAD that is not authorized	s not comply with this agreement. For example, I/we have the right to receive or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, , I/we may contact my/our financial institution or visit www.cdnpay.ca.				
Type of Service: OPersonal OBusiness					
Please attach a void cheque. (Credit card payments	are not accepted.)				
Financial Institution (FI):					
Address:	City/Town: Province: Postal Code				
FI Transit Number:	FI Account Number:				
(transit - 5 digits; FI - 3 digits) Date:	Authorized Signature(s):				
	g the premium, please have them sign and date above and complete their personal information				
Name:					
Address:	City/Town: Province: Postal Code				
Telephone Number (Business):					
Refunds for any overpayment are to be made payable	e to the applicant.				
FOR AGENT USE ONLY					
matters covered in this application and that any misre insurance and refuse coverage under the policy. I have with respect to this transaction and that I may receive products	oss, I have informed the applicant of the importance of making full and accurate disclosure of the presentations or omissions may give Medavie Blue Cross the right to cancel the contract of e disclosed the company or companies I represent and any conflicts of interest they may have a salary, commissions or other forms of compensation for the sale of insurance company				
Agent's Name: OPTIMAL FINANCIAL CENTRE INC.	Agent's Number:				
Address: 425 Notre-Dame Street					
City/Town: Dieppe	Province: New-Brunswick Postal Code: E 1 A 9 G 4				
Telephone Number: 8 8 8 - 5 0 6 - 1 1 1	$\begin{bmatrix} 2 & 5 \\ - & 5 \end{bmatrix} = \begin{bmatrix} 5 & 0 & 6 \\ - & 8 & 5 & 7 \\ - & 4 & 7 & 3 & 7 \end{bmatrix}$				
E-mail address:					
Agent's Signature:					
QUOTATION WORK SHEET:					
Health & Dental:	_				
Drugs:					
Total:					

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 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 Medavie Blue Cross.



⁷⁰¹ The Blue Cross symbol and name are registered trademarks of the Canadian Association of Blue Cross Plans, used under licence by Medavie Blue Cross, an independent licensee of the Canadian Association of Blue Cross Plans.
*Trade-mark of the Canadian Association of Blue Cross Plans.