PACIFIC BLUE CROSS™ BC Life®

Application for Optional Life
Public Education Benefits Trust

Name of employee (last, first, middle) _____ Group number _____

ID Number (SIN) _____ Class number _____ School district _____

Amount of insurance being applied for:

Employee $ _____ Spouse $ _____ Children $ _____

Beneficiary _____ Beneficiary _____ Beneficiary - Employee

Please complete for each person to be insured, listing oldest child first:

Dep. No	Status Full Name	Occupation	Birth Date (mm/dd/yy)	Sex	Height ❑ m/cm ❑ ft/in	Weight ❑ kg ❑ lb
00	Employee			❑ M ❑ F		
01	Spouse			❑ M ❑ F		
02	1st child	N/A		❑ M ❑ F		
03	2nd child	N/A		❑ M ❑ F		
04	3rd child	N/A		❑ M ❑ F		

1. Have you or your spouse had any weight change within the last 12 months?

Employee ❑ Yes ❑ No ❑ kg ❑ lb ❑ gained ❑ lost Reason _____

Spouse ❑ Yes ❑ No ❑ kg ❑ lb ❑ gained ❑ lost Reason _____

2. Have you or your spouse:

a) ever applied for or received benefits, compensation or pension because of sickness or injury? ❑ Yes ❑ No

b) been absent from work because of sickness or injury during the last six months? ❑ Yes ❑ No

3. Have you, your spouse, or your dependents:

a) undergone treatment for alcoholism or drug habit? ❑ Yes ❑ No

b) any condition for which medical consultations, treatments or medications are contemplated or have been advised? ❑ Yes ❑ No

4. Have you, your spouse, or your dependents ever consulted a physician, ever been treated for, or had any know indication of any of the following:

	Yes	No		Yes	No		Yes	No
a) high blood pressure	❑	❑	f) arthritis or rheumastism	❑	❑	k) chest pain, heart disorder, or stroke	❑	❑
b) lung disorder	❑	❑	g) hernia or bowel disorder	❑	❑	l) hepatitis B or C carrier state	❑	❑
c) cancer or tumors	❑	❑	h) stomach or liver disorder	❑	❑	m) anxiety, depression, or other mental illness	❑	❑
d) diabetes	❑	❑	i) kidney or urinary disorder	❑	❑	n) neurological disorder, seizure or multiple sclerosis	❑	❑
e) back or limb disorder	❑	❑	j) blood or circulatory disorder	❑	❑			

5. Have you, your spouse, or your dependents

	Yes	No
a) ever been treated for or had any known indication of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immunological disorder?	❑	❑
b) had any positive test results indicating exposure to the AIDS virus?	❑	❑
6. Have you, your spouse, or your dependents any physical impairments, deformities or illness not covered in questions 3,4,5 or 6?	❑	❑
7. Have you, your spouse, or your dependents consulted any physician in the last 2 years? If yes, give details below.	❑	❑
8. Are you, your spouse, or your dependents taking any prescribed medication? If yes, provide name of medication and reason for use in space provided below.	❑	❑
9. If you are female, are you currently pregnant?	❑	❑

Give complete details of all "Yes" answers to questions 2,3,4,5,6,7,8 & 9 and identify which dependent it is for.

Question no.	Dep. no.	Illness/condition	Date and duration	List types of treatment, medications and results (fully recovered or list remaining effects)	Names and full addresses of doctor(s) or hospitals

Pacific Blue Cross/BC Life & Casualty Company
PO Box 7000 Vancouver, BC V6B 4E1

Notification – please read carefully

Information regarding your insurability will be treated as confidential. Pacific Blue Cross/BC Life or its reinsurers may, however, make a brief report 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. Their address is:

Medical Information Bureau, 330 University Avenue, Toronto, Ontario M5G 1R7

Pacific Blue Cross/BC Life may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

10. a) do you or your spouse use any tobacco products? ❑ Yes ❑ No If yes, what type and how often per day?

    b) Have you or your spouse or dependent ever used marijuana, cocaine, hallucinogenic or narcotic drugs, sedatives or tranquilizers, except as prescribed by a physician? ❑ Yes ❑ No If yes, give details.

11. Have you or your spouse or dependent engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hand gliding or have you flown as a pilot, student, or crew member in the last 2 years? ❑ Yes ❑ No If yes, give details.

12. Have you or your spouse had a request for life or health insurance declined, postponed, rated, or restricted in any way? ❑ Yes ❑ No

13. Do you or your spouse now have or are you applying for other life or disability insurance? ❑ Yes ❑ No If yes, indicate type of insurance, amount, benefit and elimination periods where applicable.

Give complete details of all "Yes" answers to questions 10,11,12 or 13 and identify which dependent it is for.

Question no.	Dep. no.	Details

14. Please indicate your occupation

15. Please provide us with your family's medical history: Have your parents or siblings ever had cancer, high blood pressure, heart or kidney disease, diabetes, alcoholism or mental illness? Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Family Member	Age if living or age at death	Details of any health disorder	Cause of death (if applicable)
Employee's father			
Employee's mother			
Employee's siblings			
Spouse's father			
Spouse's mother			
Spouse's siblings			

16. Name and address of personal physician:

Authorization

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health or my dependents' health to give Pacific Blue Cross/BC Life and its reinsurers any such information. I understand this information will be used by Pacific Blue Cross/BC Life to determine my eligibility or my dependents' eligibility for coverage and may be used in connection with any claim filed with Pacific Blue Cross/BC Life. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

Date (m/d/y) _____ Home address _____

Spouse's signature (if applying) _____

Employee's signature _____ Phone number _____

☑ Check List

Please ensure all questions on both sides of this form have been answered:

- ❑ Have you indicated each family member's height, weight and date of birth?
- ❑ For all questions you answered yes to, have you:
  - ❑ indicated the dependent number?
  - ❑ provided full details to all medical questions, including dates and present condition of any illnesses or injuries?
  - ❑ provided the full names and addresses of any doctors consulted?
- ❑ Have you signed and dated the authorization?

PACIFIC BLUE CROSS™ BC Life®

Please detach and keep this stub for your records.
Please read important notice on reverse

Pacific Blue Cross/BC Life & Casualty Company
PO Box 7000 Vancouver, BC V6B 4E1

If all requested information is not provided, this form will be returned to you for further completion.