MEDAVIE BLUE CROSS™

LIFE CONVERSION APPLICATION

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
FOR ALL INQUIRIES: TEL 1-866-493-2583 FAX 1-888-764-6444

The Insured must be a resident of Canada at the time of application.

PROPOSED INSURED

Name: _____ _____ _____ _____
Title First Middle Last

Address: _____ _____ _____ _____
Street & No. City / Town Province Postal Code

Phone Number: (Bus.) _____ (Res.) _____

E-mail Address: _____ Fax Number: _____

Date of Birth (DD/MM/YYYY): _____ Age Last Birthday: _____

Place of Birth: _____ Sex*: ☐M ☐F ☐I ☐U

Date of arrival in Canada (DD/MM/YYYY): _____ First day of work in Canada (DD/MM/YYYY): _____

Name of Employer: _____ Group Number: _____ ID Number: _____

Termination Date: _____

* Sex: Male/Female/Intersex/Undisclosed – *Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

BENEFICIARY INFORMATION (for Life Conversion only)

For the Province of Québec, the designation of your spouse as beneficiary is presumed irrevocable unless otherwise specified.

☐ Revocable (Quebec Only)

First	Middle	Last	Telephone number	Relationship to the proposed insured	% share

Contingent Beneficiary - in the event of the death of the above named beneficiaries: (optional)

First	Middle	Last	Telephone number	Relationship to the proposed insured

Trustee - if beneficiary is under legal age:

For the Province of Québec, where the beneficiary of a life insurance policy is a minor at the time of the insured's death, Medavie Blue Cross will pay the proceeds to parent(s) (or other legal guardian, if applicable), and not to anyone else who might be named as administrator/trustee of the proceeds. If you wish to have another person administering the child's proceeds, you should have the proper provisions in your will. You may also want to consult with a legal counsel to determine whether there is some estate planning steps you can take to support your wishes.

First	Middle	Last	Telephone number	Relationship to the proposed insured

DETAILS OF INSURANCE FOR WHICH PROPOSED INSURED IS APPLYING

Life: ☐ Term 1 ☐ Term 65 ☐ Term 100 ☐ AD&D

Face Amount: $ _____ Face Amount (AD&D): $ _____

Premium Frequency: Monthly pre-authorized cheque

Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits

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FORM-333E 03/25

DECLARATION AND AGREEMENTS

In accordance with and subject to all the terms of the conversion privilege contained within my Individual policy, I make application to convert my insurance under said policy.

I agree that acceptance of the policy constitutes approval of its provisions and ratification of any additions or endorsements or amendments.

I agree that coverage for my insurance policy will begin the day after the termination date of my current coverage and the first premium has been paid to Medavie Blue Cross and Blue Cross Life.

In the event of death and upon request by Medavie Blue Cross or Blue Cross Life, the policyholder, beneficiary or estate administrator is expressly authorized to provide information to permit analysis and justification of the claim.

Dated at _____ in the province of _____ this _____ day of _____ year _____

Proposed Insured _____ Witness _____
(if under 16 - signature of parent/guardian) (other than primary and contingent beneficiary)

AUTHORIZATION

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 Medavie Blue Cross. 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 Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. 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 can contact Medavie Blue Cross 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 photocopy of this consent is as valid as the original.

_____ _____
Date Proposed Insured (if under 16, signature of parent/guardian)

_____
Witness (other than primary and contingent beneficiary)

BANK AUTHORIZATION

Monthly Pre-authorized Debit (PAD) - 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 for the full amount of services delivered will be debited to my/our specified account on the day of the month indicated above. 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.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Administration department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive

reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Type of Service: ☐ Personal ☐ Business

Please attach a void cheque. (Credit card payments are not accepted.)

Financial Institution (FI): **(PLEASE PRINT)** _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: | | | | | | | | | FI Account Number: | | | | | | | | | | | | |
(branch - 5 digits; FI - 3 digits)

DATE: Signature of Bank Account Holder:

If someone other than the Policy Owner will be paying the premiums, please have them sign above and complete their personal information below:

Name: _____ Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Bus.) _____ (Res.) _____