rate guide *and* application form

easy access®and preferred access®

MEDAVIE BLUE CROSS™

Plan for the future.

Plan today for your family's financial security.

Be sure your loved ones aren't left with the burden of having to pay final expenses during their time of grief.

With ***Easy Access***® and ***Preferred Access***® from Medavie Blue Cross, you can have peace of mind.

The **Benefits**

- For persons aged 40-85
- Level premiums guaranteed for life, payable to age 100
- Up to $35,000 of coverage
- No medical examinations
- Immediate death benefit
- No two-year waiting period
- Coverage guaranteed - won't be reduced
- Cash values
- Face amount doubles if death occurs due to an accident

Your **Receipt**

Please make your cheque payable to Medavie Blue Cross.

Medavie Blue Cross acknowledges receipt of the initial premium payment of $_____ paid in connection with the application for *Easy Access* life insurance on the life of _____ in the amount of $ _____ .

Signature of Agent	Date	Signature of Policy Owner

Attention Agent: *No premium is to be collected or submitted if the Proposed Life Insured has answered "**YES**" to any of the first four medical questions on the* Easy Access *and* Preferred Access *Declaration.*

Your **satisfaction** is **guaranteed**

We offer a 10-day right to examine your policy. If at any time within 10 days of receipt of your policy you are dissatisfied, simply return it to Medavie Blue Cross and we'll refund any premiums you have paid. Your satisfaction is important to us.

Annual Rates

Rates per $1,000. Based on Age Last Birthday.
Annual Policy Fee of $50.

Age	*Easy Access* Annual Rates				*Preferred Access* Annual Rates			
	Male		Female		Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker
40	21.36	36.60	17.88	27.36	12.96	25.44	9.48	18.60
41	22.08	37.80	18.48	28.08	13.44	26.40	9.84	19.32
42	22.92	39.12	18.96	28.92	14.04	27.72	10.32	20.04
43	23.76	40.56	19.56	29.76	14.76	29.04	10.80	21.00
44	24.72	42.12	20.28	30.84	15.60	30.48	11.40	21.96
45	25.68	43.80	21.00	31.92	16.56	32.16	12.00	22.92
46	26.64	45.60	21.60	33.24	17.64	33.96	12.84	24.12
47	27.72	47.64	22.32	34.56	18.72	35.88	13.68	25.32
48	28.80	49.68	23.16	36.00	20.04	38.04	14.76	26.76
49	30.12	51.96	24.00	37.44	21.36	40.20	15.72	28.08
50	31.44	54.36	24.96	39.00	22.80	42.36	16.68	29.52
51	32.88	57.00	26.04	40.68	24.12	44.64	17.64	30.96
52	34.44	59.76	27.36	42.24	25.32	46.92	18.60	32.40
53	36.12	62.64	28.68	43.92	26.76	49.32	19.56	33.96
54	38.04	65.88	30.12	45.84	28.20	51.84	20.64	35.64
55	39.96	69.36	31.56	47.76	29.88	54.60	21.84	37.32
56	42.12	72.96	33.12	49.92	31.68	57.48	23.16	39.24
57	44.52	76.92	34.80	52.20	33.72	60.60	24.60	41.16
58	46.92	81.00	36.48	54.60	35.88	63.84	26.16	43.32
59	49.68	85.44	38.40	57.12	38.04	67.20	27.84	45.60
60	52.68	90.24	40.44	60.00	40.20	70.80	29.52	48.00
61	55.80	95.40	42.60	63.00	42.12	74.64	31.08	50.52
62	59.28	100.80	44.88	66.12	44.04	78.60	32.88	53.28
63	62.88	106.56	47.28	69.60	46.08	82.80	34.56	56.04
64	66.84	112.80	50.04	73.32	48.36	87.12	36.60	59.16
65	71.28	119.40	53.04	77.28	51.24	91.80	38.76	62.40
66	76.08	126.36	56.28	81.60	54.72	96.72	41.28	65.88
67	81.12	133.68	59.76	86.16	58.56	101.76	43.92	69.48
68	86.64	141.48	63.48	91.08	62.76	107.04	46.80	73.44
69	92.64	149.88	67.56	96.36	67.32	112.68	49.92	77.52
70	99.12	159.00	72.12	102.36	71.88	118.68	53.28	82.08
71	106.20	168.72	76.92	108.72	76.56	125.04	56.88	86.88
72	113.76	178.92	81.84	115.44	81.36	131.76	60.60	91.80
73	121.80	189.96	87.36	122.76	86.52	138.72	64.68	97.08
74	130.68	201.72	93.36	130.80	91.92	146.28	69.00	103.08
75	140.40	214.56	100.20	139.92	97.80	154.20	73.80	109.92
76	150.48	227.88	107.52	149.88	103.44	161.28	78.60	117.24
77	161.04	241.56	114.96	160.44	108.84	167.40	83.28	124.80
78	172.44	256.44	123.36	171.96	114.84	174.72	88.44	133.20
79	185.52	273.24	133.20	184.68	122.88	185.28	95.04	143.16
80	200.88	292.68	145.08	198.60	133.92	201.00	103.56	155.28
81	218.52	314.88	159.12	213.84	147.96	221.88	114.00	169.68
82	237.96	339.24	174.84	230.16	164.28	246.72	126.00	185.64
83	259.20	365.76	192.36	247.68	182.88	275.40	139.44	203.40
84	282.24	394.56	211.44	266.40	203.76	307.92	154.44	222.96
85	307.20	425.52	232.20	286.32	226.92	344.40	171.00	244.08

Monthly Rates (PAD)

Rates per $1,000. Based on Age Last Birthday.
Monthly Policy Fee of $4.50.

Age	*Easy Access*				*Preferred Access* Monthly Rates			
	Male		Female		Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker
40	1.92	3.29	1.61	2.46	1.17	2.29	0.85	1.67
41	1.99	3.40	1.66	2.53	1.21	2.38	0.89	1.74
42	2.06	3.52	1.71	2.60	1.26	2.49	0.93	1.80
43	2.14	3.65	1.76	2.68	1.33	2.61	0.97	1.89
44	2.22	3.79	1.83	2.78	1.40	2.74	1.03	1.98
45	2.31	3.94	1.89	2.87	1.49	2.89	1.08	2.06
46	2.40	4.10	1.94	2.99	1.59	3.06	1.16	2.17
47	2.49	4.29	2.01	3.11	1.68	3.23	1.23	2.28
48	2.59	4.47	2.08	3.24	1.80	3.42	1.33	2.41
49	2.71	4.68	2.16	3.37	1.92	3.62	1.41	2.53
50	2.83	4.89	2.25	3.51	2.05	3.81	1.50	2.66
51	2.96	5.13	2.34	3.66	2.17	4.02	1.59	2.79
52	3.10	5.38	2.46	3.80	2.28	4.22	1.67	2.92
53	3.25	5.64	2.58	3.95	2.41	4.44	1.76	3.06
54	3.42	5.93	2.71	4.13	2.54	4.67	1.86	3.21
55	3.60	6.24	2.84	4.30	2.69	4.91	1.97	3.36
56	3.79	6.57	2.98	4.49	2.85	5.17	2.08	3.53
57	4.01	6.92	3.13	4.70	3.03	5.45	2.21	3.70
58	4.22	7.29	3.28	4.91	3.23	5.75	2.35	3.90
59	4.47	7.69	3.46	5.14	3.42	6.05	2.51	4.10
60	4.74	8.12	3.64	5.40	3.62	6.37	2.66	4.32
61	5.02	8.59	3.83	5.67	3.79	6.72	2.80	4.55
62	5.34	9.07	4.04	5.95	3.96	7.07	2.96	4.80
63	5.66	9.59	4.26	6.26	4.15	7.45	3.11	5.04
64	6.02	10.15	4.50	6.60	4.35	7.84	3.29	5.32
65	6.42	10.75	4.77	6.96	4.61	8.26	3.49	5.62
66	6.85	11.37	5.07	7.34	4.92	8.70	3.72	5.93
67	7.30	12.03	5.38	7.75	5.27	9.16	3.95	6.25
68	7.80	12.73	5.71	8.20	5.65	9.63	4.21	6.61
69	8.34	13.49	6.08	8.67	6.06	10.14	4.49	6.98
70	8.92	14.31	6.49	9.21	6.47	10.68	4.80	7.39
71	9.56	15.18	6.92	9.78	6.89	11.25	5.12	7.82
72	10.24	16.10	7.37	10.39	7.32	11.86	5.45	8.26
73	10.96	17.10	7.86	11.05	7.79	12.48	5.82	8.74
74	11.76	18.15	8.40	11.77	8.27	13.17	6.21	9.28
75	12.64	19.31	9.02	12.59	8.80	13.88	6.64	9.89
76	13.54	20.51	9.68	13.49	9.31	14.52	7.07	10.55
77	14.49	21.74	10.35	14.44	9.80	15.07	7.50	11.23
78	15.52	23.08	11.10	15.48	10.34	15.72	7.96	11.99
79	16.70	24.59	11.99	16.62	11.06	16.68	8.55	12.88
80	18.08	26.34	13.06	17.87	12.05	18.09	9.32	13.98
81	19.67	28.34	14.32	19.25	13.32	19.97	10.26	15.27
82	21.42	30.53	15.74	20.71	14.79	22.20	11.34	16.71
83	23.33	32.92	17.31	22.29	16.46	24.79	12.55	18.31
84	25.40	35.51	19.03	23.98	18.34	27.71	13.90	20.07
85	27.65	38.30	20.90	25.77	20.42	31.00	15.39	21.97

Minimum Premium $200 Yearly, $20 Monthly

For other billing frequencies, multiply Annual Rates by:
Quarterly billing: multiply by .27 **Semi-annual billing: multiply by .525**

Cash Values

Per $1,000 of face amount

Easy Access®

Age Last Birthday* Male/Female	Cash Values at the End of:				
	3 Years	5 Years	10 Years	15 Years	20 Years
40	$ 25	$ 27	$ 32	$ 45	$ 69
45	30	32	40	60	90
50	35	40	55	85	125
55	45	55	80	115	180
60	60	75	110	165	250
65	80	100	150	225	330
70	110	145	195	285	420
75	145	175	250	395	620
80	175	210	350	565	1,000
85	195	235	485	1,000	_

Preferred Access®

Female

Age Last Birthday*	Cash Values at the End of:				
	3 Years	5 Years	10 Years	15 Years	20 Years
40	$ 17	$ 18	$ 24	$ 34	$ 56
45	20	23	29	46	74
50	24	28	41	67	105
55	30	38	60	94	158
60	41	53	85	139	229
65	54	72	120	201	324
70	74	105	166	277	421
75	98	132	240	396	619
80	118	153	302	564	1,000
85	132	181	484	1,000	_

Male

Age Last Birthday*	Cash Values at the End of:				
	3 Years	5 Years	10 Years	15 Years	20 Years
40	$ 21	$ 22	$ 27	$ 39	$ 62
45	25	27	34	53	81
50	29	33	47	76	114
55	37	46	70	104	168
60	50	63	97	151	239
65	66	84	134	212	327
70	91	124	179	281	420
75	120	152	245	395	620
80	144	179	324	565	1,000
85	161	206	485	1,000	_

**Age Last Birthday* is based on the age of the life insured as of the policy effective date.*

Complete listing of cash values available upon request.

MEDAVIE BLUE CROSS™
PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511
FAX: 506-869-9654

Application for Life Insurance

Benefits are underwritten by Blue Cross Life Insurance Company of Canada

Name of Proposed Life Insured

Name: _____ (First) _____ (Middle) _____ (Last)

Mailing Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: ____ - ____ - _____

Date of Birth: _____ (Day/Month/Year) Age Last Birthday: _____ Gender: ○ Male ○ Female

Occupation: _____

Name of Policy Owner
(If different from Proposed Life Insured)

Name: _____ (First) _____ (Middle) _____ (Last)

Mailing Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: ____ - ____ - _____

Relationship to Proposed Life Insured: _____ Name of Contingent Policy Owner: _____

Note: *If no contingent policy owner is named, all of the policy owner's rights and interest in this policy will be transferred to the policy owner's estate at the time of death of the policy owner.*

U.S. Residency Tax Information

Tax residency information must be completed by the policy owner. The proposed life insured is also the policy owner if no policy owner is indicated.

Are you a US citizen or a US resident for tax purposes?

○ Yes Please provide your Individual Taxpayer Identification Number (ITIN) or SSN: _____

○ No

If a contingent policy owner is indicated, please also provide details.

Is the contingent policy owner a US citizen or a US resident for tax purposes?

○ Yes Please provide their Individual Taxpayer Identification Number (ITIN) or SSN: _____

○ No

Name of Beneficiary or Beneficiaries
If more than one beneficiary, the proceeds will be divided in equal shares among surviving beneficiaries, unless otherwise indicated below.

Primary Beneficiary/Beneficiaries:

Name: _____ Telephone: ____ - ____ - _____

Relationship to Life Insured: _____ % Share _____

Name: _____ Telephone: ____ - ____ - _____

Relationship to Life Insured: _____ % Share _____

Name: _____ Telephone: ____ - ____ - _____

Relationship to Life Insured: _____ % Share _____

Total 100% _____

Contingent Beneficiary/Beneficiaries:

Name: _____ Telephone: ____ - ____ - _____ Relationship to Life Insured: _____

Name: _____ Telephone: ____ - ____ - _____ Relationship to Life Insured: _____

Face Amount Applied for

Easy Access	$ _____	Premium $ _____
Preferred Access	$ _____	Premium $ _____

Initial payment should always be based on ***Easy Access*** premium.

Please note: A physician's signature will be required to verify medical information based on the following:

Easy Access

Age 75-85 for any face amount

Preferred Access

Age 40-59 for face amount over $10,000
Age 60-69 for face amount over $ 7,500
Age 70-74 for face amount over $ 5,000
Age 75-85 for any face amount

Method of Payment

A: Direct Billing: ◯ **Annual** ◯ **Semi-annual** ◯ **Quarterly**

B: Monthly Pre-authorized Debit (PAD): ◯ **1st** ◯ **15th** **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: | | | | | | | | | (transit - 5 digits; FI - 3 digits) FI Account Number: | | | | | | | | | | | | |

DATE: _____ Authorized Signature(s): _____

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.) ___ - ___ - _____

Agent **Checklist** ☑

Prior to submitting applications, be sure to complete the following:

- ◯ My client has signed the ***Easy Access*** and ***Preferred Access*** Declaration.
- ◯ I've indicated in the "Note to Attending Physician" section what my client's attending physician must verify and sign.
- ◯ I've indicated my client's bank authorization information on the application.
- ◯ A void cheque is enclosed.
- ◯ I've verified the identity of the applicant.
- ◯ I've indicated my agent number below.
- ◯ I've included a premium for ***Easy Access*** rate. (No post-dated cheques)

By signing below you confirm that you, the agent, have disclosed:

a) the company or companies you represent;
b) that you receive commissions for the sale of life and health insurance company products;
c) that you may receive additional compensation in the form of bonuses, conference programs or incentives; and
d) any conflicts of interest you may have in respect to this transaction.

Agent's Name: Bernice Piercey
PLEASE PRINT

Agent's Address: _____

Agent's Number: 9319

Phone Number: 888-339-5433 Fax Number: 709-646-2823

E-mail: islandwidefinancial@nfld.net

Signature: _____

Policy should be sent to: ◯ Agent ◯ Policy Owner

Note to Attending Physician

Name (Proposed Life Insured): _____ Date of Birth: _____
(Day / Month / Year)

○ Please review the answers to Medical Questions 1-4 within the ***Easy Access*** and ***Preferred Access*** Declaration below and confirm and sign the ***Easy Access*** section of the Attending Physician's Verification on the next page.

OR

○ Please review the answers to Medical Questions 1-10 within the ***Easy Access*** and ***Preferred Access*** Declaration below and confirm and sign the ***Preferred Access*** section of the Attending Physician's Verification on the next page.

Easy Access® and Preferred Access® Declaration

Please note: *all questions that inquire about specific periods of time are to be answered counting back from (and including) the actual date you sign this application.*

Non-medical *Questions*

- Have you smoked any tobacco or used tobacco or nicotine in any form (including nicotine replacement products) or used any smoking cessation products or used hashish or marijuana in the last 12 months? ○ Yes ○ No
- Is this insurance intended to replace, change or modify any existing life insurance policy(ies) or any life insurance policy(ies) cancelled within the last six months (not including any employer-sponsored group policies)? If yes, please complete a Life Insurance Replacement Declaration (LIRD). ○ Yes ○ No

If applying for ***Easy Access***, please answer questions 1-4.
If applying for ***Preferred Access***, please answer questions 1-10.

*Easy Access® **Medical** Questions*

1. Are you currently hospitalized or confined to a ***nursing care home***[1], OR within the last 12 months have you been hospitalized two or more times? ○ Yes ○ No

   [1]*Nursing Care Home* - persons confined to a residential facility, including government and independent facilities and those operated within a hospital or retirement village, who require active daily nursing care.

2. a) Within the last two years have you been diagnosed with OR hospitalized for any of the following: stroke, heart attack, heart surgery, heart failure (water/fluid on the lungs), angina OR: ○ Yes ○ No
   b) Within the last three years have you been diagnosed with OR hospitalized for malignant cancer (other than basal cell carcinoma)? ○ Yes ○ No

3. Within the last year:
   a) Have you been advised by a physician to have any of the following that has either not been completed or the results are unknown: surgery, diagnostic testing, an investigation or a referral: ○ Yes ○ No
   b) Have you used oxygen equipment to assist in breathing? ○ Yes ○ No

4. Have you ever been diagnosed with, treated for, or had any indication of HIV infection or AIDS, OR within the last five years have you been diagnosed with ***chronic***[2] kidney or liver disease or received a major organ transplant? ○ Yes ○ No

   [2]*Chronic* - A disease or condition that persists over a long period of time.

If any above question is answered with a "YES," please provide complete details of any and all conditions including dates, diagnosis, treatment, results and whether the condition(s) is (are) under control. (Attention Agent: If this portion of the application is to be completed, no premium is to be collected until requested by Medavie Blue Cross.)

Remarks: _____

*Preferred Access® **Medical** Questions*

5. Have you ever been diagnosed with or treated for any of the following: ***chronic***[2] liver or kidney disease, organ transplant, Alzheimer's or Parkinson's disease, multiple sclerosis or ALS (Lou Gehrig's disease)? ○ Yes ○ No

   [2]*Chronic* - A disease or condition that persists over a long period of time.

6. Within the last **10 years**, have you been diagnosed with, treated for or hospitalized for any of the following: stroke, heart attack, angina, heart surgery or malignant cancer (other than basal cell carcinoma)? ○ Yes ○ No

7. Within the last **five years**, have you been diagnosed with, treated for or hospitalized for any of the following: heart failure (water/fluid on the lungs), aneurysm, insulin diabetes, **chronic** obstructive lung disease (including emphysema and **chronic** bronchitis), alcoholism, Crohn's disease or ulcerative colitis? ○ Yes ○ No

8. Within the last **year**, have you been diagnosed with, treated for or referred to a specialist for any of the following:
   a) TIA (mini-stroke), ○ Yes ○ No
   b) irregular heartbeat or irregular pulse, ○ Yes ○ No
   c) abnormal electrocardiogram (ECG), ○ Yes ○ No
   d) abnormal blood tests or other medical tests? ○ Yes ○ No

9. Current Height: _____ ' _____ " or _____ cm; Weight: _____ lbs or _____ kg.

10. Are you currently taking any prescription medication? ○ Yes ○ No
    (If yes, please provide the following details. If you need more room, please attach a separate sheet.)

	Medication	*Medication*	*Medication*
Name(s) of medication:			
Reason for taking medication:			
Duration of treatment:			
Is the medication controlling your symptoms?			
Date diagnosed with condition:			

If more than three medications, indicate name(s) of additional medication(s) here: _____

◯ I am applying for *Easy Access*® life insurance.

If you've answered "NO" to medical questions 1-4 on the previous page:
I understand and agree that, if I've answered "NO" to medical questions 1 to 4 on Page 6 on the date I've signed and dated this application, I am eligible for insurance coverage in the amount for which I've applied effective immediately, provided the initial payment is paid in full, **and the attending physician's signature, if required, confirms the "NO" answers to the medical questions.**

If you've answered "YES" to any medical question from 1 to 4 on the previous page:
If I have answered "YES" to any one of medical questions 1 to 4 on Page 6 of this application, then I understand and agree that no coverage is in effect until a review of the medical history has been completed, the initial premium is paid in full and a policy is issued by Medavie Inc., operating under the business name Medavie Blue Cross, and Blue Cross Life Insurance Company of Canada.

I apply for *Easy Access* life insurance and declare that all answers given concerning this application and declaration are full, complete and true.

Please be advised that any incorrectly answered questions or false statements on this application or declaration may result in Blue Cross Life Insurance Company of Canada/Medavie Blue Cross declaring the policy void. Blue Cross Life Insurance Company of Canada/Medavie Blue Cross reserves the right to levy an expense recovery fee under these circumstances.

◯ I am applying for *Preferred Access*® life insurance.

I apply for *Preferred Access* life insurance and declare that all answers given concerning this application and declaration are full, complete and true.

I understand and agree that this insurance is not in effect until a review of the medical history has been completed, the initial premium is paid in full and a policy is issued by Blue Cross Life Insurance Company of Canada/Medavie Blue Cross.

If *Preferred Access* is declined, *Easy Access* will be issued based on premium received.

Please be advised that any incorrectly answered questions or false statements on this application or declaration may result in Blue Cross Life Insurance Company of Canada/Medavie Blue Cross declaring the policy void. Blue Cross Life Insurance Company of Canada/Medavie Blue Cross reserves the right to levy an expense recovery fee under these circumstances.

Easy Access and *Preferred Access*

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 any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, or other organization, institute or person, that has any records or knowledge of me or my health, to give Blue Cross Life, Medavie Blue Cross or their reinsurer any such information. I further 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. 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 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.

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.

This consent complies with federal and provincial privacy laws. A photocopy of this consent is as valid as the original.

Signature of Policy Owner _____ Signature of Proposed Life Insured _____

Signature of Witness *(other than beneficiary)* _____ Printed Name of Witness _____

Dated at: _____ on this _____ day of _____ year _____

Attending Physician's Verification

◯ ***Easy Access***®
I have reviewed the Proposed Life Insured's answers to non-medical and medical questions 1 to 4 on Page 6 and to the best of my knowledge the answers given are correct.

◯ ***Preferred Access***®
I have reviewed the Proposed Life Insured's answers to non-medical and medical questions 1 to 10 on Page 6 and to the best of my knowledge the answers given are correct.

Remarks: _____

IMPORTANT: Verification must be substantiated by review of this person's documented medical history.

Date	Attending Physician's Full Name (*please print*)	Attending Physician's Signature

Attending Physician's Contact Information
(to be completed by agent)

Name: _____

Telephone Number: _____

BRO-034E 02/16