PACIFIC BLUE CROSS™

Travel Plan Application

Broker Code: CUM001

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

Submit this form to: David Cummings Insurance Services

info@david-cummings.com fax: (604) 228-9807 call: (604) 228-8816

TRIP INFORMATION

Annual plan effective date (mm/dd/yy)		
Single trip plan departure date (mm/dd/yy)	Return date (mm/dd/yy)	Destination

TRIP CANCELLATION COVERAGE (to be eligible you must have made your first non-refundable deposit for your trip within the last 72 hours/3 days.)

Do you wish to purchase? ☐ Yes ☐ No	Average pre-paid cost of trip per person ($)

OTHER HEALTH COVERAGE WITH PACIFIC BLUE CROSS

Group number	I.D. number

APPLICANT INFORMATION

Surname		First name		Birth date (mm/dd/yy)
☐ M ☐ F	Address	City		Postal code
Daytime phone number ( )	E-mail address	Social insurance number (optional)	BC Care Card number	

DEPENDANTS (includes person(s) accompanying you on your trip. Example: spouse and/or dependant children under 21 or under 25 if full-time student.)

1	Surname	First name	Birth date (mm/dd/yy)	☐ M ☐ F
2	Surname	First name	Birth date (mm/dd/yy)	☐ M ☐ F
3	Surname	First name	Birth date (mm/dd/yy)	☐ M ☐ F
4	Surname	First name	Birth date (mm/dd/yy)	☐ M ☐ F

BENEFICIARY DESIGNATION (complete only if your selected plan includes Accidental Death and Dismemberment or Air Flight Accident.)

1	Surname	First name	Birth date (mm/dd/yy)	☐ M ☐ F

Please call 604 419-2200 or Toll free outside Greater Vancouver 1-800-USE-BLUE (1-800-873-2583) to obtain a quote and information on various competitive plan options or visit our website at www.pac.bluecross.ca.

SELECT FROM THE FOLLOWING TRAVEL PLANS

☐ Annual Medical Plan (non-refundable) for ☐ 15 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days		
☐ Annual Package Plan (non-refundable) for ☐ 10 days ☐ 17 days ☐ 24 days ☐ 31 days		Previous Annual Certificate number with PBC
☐ Individual Daily Plan	☐ Individual Daily Package Plan	☐ Canada Package Plan (entire trip must be within the Canadian borders)
Quoted cost ($)	**Provided by (Customer Service Representative name)**	

For persons 61 years or older, please complete the enclosed Health Declaration 2 to determine the rate for the plan you selected.

PAYMENT INFORMATION

☐ MasterCard ☐ Visa ☐ American Express ☐ Cheque		Credit card number
Expiry (mm/yy)	Cardholder name **(printed)**	Signature

I am aware of the exclusions, limitations and terms of this Travel Coverage Agreement. I understand that this is a MEDICAL EMERGENCY TRAVEL plan only. **I understand that this Agreement does not cover pre-existing medical conditions.** I understand that individuals traveling outside British Columbia for the purpose of obtaining hospital and or medical treatment will not be covered for that treatment by this plan, and failure to call the Travel Assistance Provider Emergency number(s), as outlined in the Travel Plan Policy, may result in benefits being denied. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other related facility, that has records or knowledge of me or my health, or the health of my covered dependents, to release this information to Pacific Blue Cross or it's agents, upon request, in the event of a claim under this plan. Any information provided by me in relation to this contract or any other contract with Pacific Blue Cross or a Blue Cross organization may be used by you in adjudicating claims for me and my dependents. I declare the information supplied on this application is correct and accurate. Falsification of information will render this coverage void.

X _____

Signature of applicant or proxy — Date (mm/dd/yy)