MEDAVIE BLUE CROSS™

INDIVIDUAL HEALTH EXCLUSION QUESTIONNAIRE

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
FOR ALL INQUIRIES: TEL 1-800-667-4511 FAX (506) 867-4651

ID # _____ Name of Subscriber _____

To reconsider removing the exclusion(s) and/or rating from your policy, you are required to answer the following questions. If more than one exclusion is to be reconsidered, please complete a form for each exclusion.

Exclusion _____ for _____
(indicate name of exclusion) (name of person with the exclusion)

OR

Rating for _____
(name of person with the rating)

1. When was the last date you consulted a doctor for your condition(s)? _____

2. Since when have you been symptom free regarding your condition(s)? _____

3. When was the last date of any treatment/medication for your condition(s)? _____

I, the undersigned, declare the answers to the above questions are complete and accurate. Medavie Blue Cross reserves the right to recover any monies paid on my/our behalf or on the behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this form. I/we agree to repay to Medavie Blue Cross any and all monies paid as a result of the discovery of facts not fully disclosed on this form.

Date _____

Signature of Subscriber _____

Signature of Spouse _____
(if spouse is the person with the exclusion)