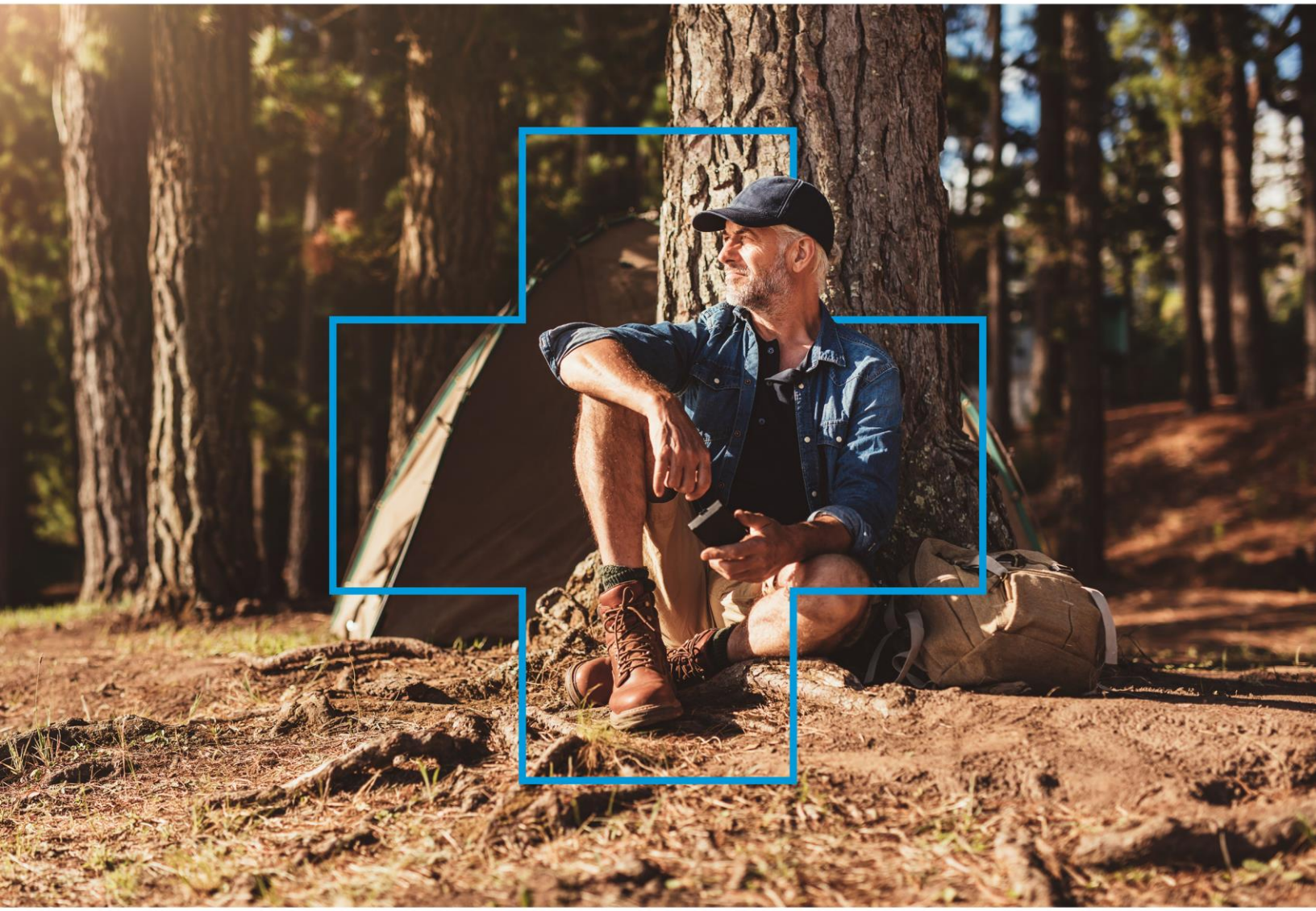
Blue Cross Health™

A PLAN THAT'S RIGHT FOR YOU



Advisor's Guide

Last update: 2024-05

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Table of Contents

1. INTRODUCTION

This guide contains the main guidelines and procedures related to the administrative cycle of Blue Cross® Health plan insurance contracts. This document contributes to the consistency of our operations, therefore ensuring you and your client's quality service and compliance with recognized sound business practices.

Among other things, you will find information on:

- Submitting an application
- Underwriting process
- Contract administration
- Submitting claims
- Partner compensation

This guide is divided into several sections. Please refer to the table of contents to easily find the information you are looking for.

2. CONTACT US

Commissions and Contracting

Telephone	514-286-2626 1-800-361-2538 (option 2, then option 2)
Email	Quebec: commission.contracting@qc.bluecross.ca Ontario: commission.contracting@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the secured file transmission form on our website under 'Distribution Agreement' request type. Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 4:30 p.m.
Service standards Return calls and general emails	24 hours from Monday to Friday (except legal holidays)

Info-Partners Health

Telephone	514-286-2626 1-800-361-2538 (option 2, then option 1)
Email	Quebec: info.partners.health@qc.bluecross.ca Ontario: info.partners.health@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the secured file transmission form on our website under 'Everything related to your contract' request type. Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 4:30 p.m.
Service standards Return calls and emails	24 hours from Monday to Friday (except legal holidays)

Health and Dental claims (For questions regarding Health and Dental claims, please advise clients to contact the Customer Relations Centre)

Telephone	1- 844-745-6780
Email	Quebec: service@qc.bluecross.ca Ontario: bco.service@ont.bluecross.ca
Documents transmission	Documents submitted by clients containing personal information must be sent through the secured file transmission form on our website under 'Health, drugs or dental claim' request type. Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot
Member service site or mobile app	Ontario: https://www.medaviebc.ca/en/ontarioplans/members Quebec: https://www.medaviebc.ca/en/quebecplans/members Or download the free **Blue Cross Mobile** (Medavie, Ontario, Quebec) app from the *Apple app store* or *Google Playstore*
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 5 p.m.

Mailing address for the Contract Administration and Underwriting services

Quebec	Ontario
1981 McGill College Avenue, Suite 105 Montreal, QC H3A 0H6	Ontario Blue Cross P.O. Box 4433, Station A Toronto, ON M5W 3Y7

Mailing address for health and dental claims

Quebec	Ontario
P.O. Box 1630, Station B Montreal, QC H3B 3L3	Ontario Blue Cross P.O. Box 4433, Station A Toronto, ON M5W 3Y7

3. NEW BUSINESS – Processing the application and issuing the contract

3.1. Service standards

Administrative delays	Two (2) business days
Underwriting delays	Two (2) business days

3.2. Personal information

Protecting the privacy of personal information is one of our top priorities.

To ensure that documents containing personal information are transmitted in a secure way, they must be submitted via the secured file transmission form available on our website under the request type 'Everything related to your contract':
Ontario: https://on.bluecross.ca/depot
Quebec: https://qc.bluecross.ca/depot

Examples of personal information	Personal information includes, but is not limited to: • Name • Date of birth • Medical information • Address • Phone number • Billing information • Identification numbers • Marital and dependent status
Documents transmission	The following documents must be sent through the secured file transmission form on our website: • Pre-authorized debit (PAD) agreement • Request for modification of an existing contract (change of address, banking information, contract cancellation, etc.) • Documents submitted for a claim. • Proof of loss of coverage The original of any document sent must be kept by the advisor for the duration of the contract.

3.3. Digital signature

Electronic signatures accepted	Here is the list of accepted digital signature solutions if accompanied by an authentication certificate: • Adobe Sign • Authentisign • DocuSign®* • Dropbox Sign • eZsign • NexOne Sign • OneSpan Sign • Stylus* • iGeny *DocuSign and Stylus electronic signatures do not require an authentication certificate. **Important**: Please note that we do not accept the transfer of documents from sources that are difficult to verify (example: Adobe Creative Cloud, WeTransfer, Google Drive.)

3.4. Plans

To be eligible for the Blue Cross Health plans, subscribers must be residents of Ontario or Quebec who are covered by government health care coverage (OHIP or RAMQ).
Please be reminded that subscribers must meet the definition of applicant, spouse or child and that they must complete any applicable waiting periods.

Complete Health	The Complete Health plan is a medically underwritten plan that allows applicants to choose the benefits that best meet their needs and budget and can be changed as clients go through life's stages.
Guaranteed Acceptance	The Guaranteed Acceptance plan provides basic health benefits for routine medical expenses. With no medical underwriting, our Guaranteed Acceptance plan covers pre-existing conditions. Since the Drug benefit in this plan is mandatory, subscribers in Quebec must be enrolled in the Public Prescription Drug Insurance Plan (PPDIP) administered by the RAMQ or have an equivalent group insurance.
Assured Access	Assured Access provides future access to a comprehensive personal health plan, without additional medical underwriting, in the event your client no longer qualifies for group benefits. This plan can be subscribed to as an optional module with Complete Health plan, or as a standalone plan.

Additional requirement to be eligible for the standalone plan, the client must:

- Have group coverage with health and drugs
- Provide proof of health
- Be 64 years old or younger

3.4.1. Types of plans

Plans / Benefits (modules)	Guaranteed Acceptance	Complete Health			Assured Access (standalone plan)
		Entry	Essential	Enhanced	
Health benefit	Mandatory	Mandatory	Mandatory	Mandatory	n/a
AD&D benefit	Included	n/a	Included (64 years of age and under)	Included (64 years of age and under)	Included
Dental benefit	Mandatory	Optional	Optional	Optional	Optional
Travel benefit	Optional	n/a	n/a	Included (Optional at age 65 and over)	Optional
Drug benefit*	Mandatory (Optional at age 65 and over)	n/a	Optional	Optional	n/a
Critical Illness benefit	n/a	Optional	Optional	Optional	Optional
Hospital Cash benefit	n/a	Optional	Optional	Optional	Optional
Assured Access benefit	n/a	Optional	Optional	Optional	n/a

*Note that the Drug benefit in the Complete Health plan has only two levels of coverage: Essential and Enhanced. Any one of these two levels can be selected on a Complete Health plan with Entry level Health benefit.

Blue Cross Health plan guides are available on the Advisor resources web page:
Ontario: https://on.bluecross.ca/advisor-resources/products
Quebec: https://qc.bluecross.ca/advisor-resources/products

3.4.2. Policy definitions

Applicant	The person named on the application for coverage under this policy and whose application has been accepted by Blue Cross.
Child	A person who: • is a resident of Ontario or Quebec • is covered by a government health care benefit (OHIP or RAMQ) • is a natural or adopted child of the applicant or spouse, or a child over whom the applicant or spouse has been appointed as guardian with parental authority • is financially reliant on the member or spouse for care, maintenance and support • is not married or in a common law relationship; and • meets one of the following criteria: a) is under age 21 b) is under age 26 and is attending an accredited educational institution, college or university on a full-time basis; or c) became mentally or physically disabled while a child as defined in a) or b) and has been continuously disabled since that time. A child is considered to be mentally or physically disabled if they are incapable of engaging in any substantially gainful activity and are financially reliant on the applicant for care, maintenance and support due to this disability (special dependent). Blue Cross must be notified of any dependents 21 years of age and over (up to their 26th birthday) who are full-time students at an accredited school, university or college. The applicant is responsible for notifying Blue Cross when dependents no longer meet the definitions outlined here.
Dependent	The spouse or child of a applicant. Dependents must be named in the application for enrolment or in any subsequent application accepted by Blue Cross.
Newborn child	A child 31 days of age or under.
Spouse	The person who: • is a resident of Ontario or Quebec • is covered by a government health care benefit (OHIP or RAMQ); and • meets one of the following criteria: ○ is married to the applicant ○ has been living with the applicant in a conjugal relationship for at least 1 year; or ○ resides at the same address as the applicant, does not qualify as a dependent child under the policy and is named in an application by the applicant. The spouse must be designated by the applicant on their application for benefit. Only one person may be covered as a spouse at any one time.

Please refer to the policy for the complete list of definitions.

3.4.3. Value-added benefits

Blue Advantage®	Blue Advantage® allows clients to enjoy exclusive discounts on the total cost of products and services from participating providers across Canada, regardless of whether the item is covered under your benefit plan. Offered on all products: http://www.blueadvantage.ca
Online Doctors (Ontario only)	Online Doctors provide quick access to a physician from a computer, phone or tablet for diagnosis, medical advice and treatment. It includes three consultations per year per family and the services are available Monday to Friday, 7am to midnight ET (17 hours per day). Only offered to Ontario clients with a Complete Health product: http://www.getmaple.ca/OntarioBlueCross
inConfidence program	The inConfidence program is a confidential assistance service offering counselling and support by a network of qualified counsellors and consultants via telephone, in person, and online 24 hours a day, 7 days a week. It offers 5 hours of individual and 5 hours of couple counselling with a qualifies professional per year. Offered on all products: https://www.medaviebc.ca/en/members/your-coverage/inconfidence
My Good Health® wellness portal	My Good Health® offers advice, information, and tips for clients on how to be and stay healthy. It also includes an interactive health risk assessment tool to assess their current health, set and track personal goals. Offered on all products: https://www.medaviebc.ca/en/members/your-coverage/mygoodhealth

3.5. Submitting a new application

3.5.1. Online applications and electronic signatures

All Blue Cross Health applications must be submitted online, through Salesforce. There are no paper applications available for this line of health plans.

Therefore, the application must be signed electronically by all parties.

- An email address is mandatory for each insured (Applicant & Spouse)*
- An email address is mandatory for the payer if different from the applicant

*The email address for Applicant and Spouse must be different. It is not possible to use the same email address for both insured and/or the payer.

3.5.2. Proof of loss

The waiting period can be waived on applications that were made within 60 days of losing a group health benefit or an individual plan.

The applicant must provide a proof of loss* (POL), issued by the previous insurance company or place of employment, showing that their previous benefit was lost within 60 days of applying for the new Blue Cross Health Plan (Guaranteed Acceptance or Complete Health plans).

Required information from the previous contract	The document provided by the client must be a letter or email produced directly from the previous Insurer or employer showing the following information: • Termination date** • Benefits lost • Persons covered An email written by the client will not be accepted.
Waiting period can be waived for the following benefits	• Hearing Aids • Vision Care • Dental benefit • Semi-private hospital room related to a pregnancy

*There is no time frame to submit the proof of loss. The waiting period will be waived as soon as the proof is received and if the **application** was done **within 60 days from the coverage loss**.

The waiting period can only be waived if the **other coverage is terminated, otherwise, both plans will be effective, and the coordination of benefits will apply.

3.5.3. Travel optional benefit on Guaranteed Acceptance application

The Travel benefit is currently not offered during the online application process of a Guaranteed Acceptance plan.

Requirements to subscribe to the Travel optional benefit	• Refer to the Guaranteed Acceptance **Rate guide** for the total amount of premium including the Travel benefit • Confirm monthly premium to applicant • Complete the online application for the other benefits • On the “Agent consent” page in Salesforce, please use the **comment** section to indicate that your client wishes to purchase the Travel optional benefit and has been informed of the total monthly premium to be paid

3.6. Policy effective date

The effective date of a policy is always the 1st of the month.

Without previous coverage			
Issuing Date	**Date Option**	**Effective Date of the Policy**	**Particularities**
1st to 20th (inclusive) of the month	According to option selected	1st day of the following month 1st day of the 2nd following month 1st day of the 3rd following month	n/a
	Backdating	1st day of the current month	The request must be included in the opportunity description.
21st to 31st (inclusive) of the month	According to option selected	1st day of the following month 1st day of the 2nd following month 1st day of the 3rd following month	n/a
	Backdating	Not allowed	n/a

With previous coverage			
Issuing Date	**Date Option**	**Effective Date of the Policy**	**Particularities**
1st to 20th (inclusive) of the month	According to option selected	1st day of the following month 1st day of the 2nd month 1st day of the 3rd month	Without Proof of Loss of Coverage.
	Backdating	1st day of current month	Without Proof of Loss of Coverage. The request must be included in the opportunity description.
		1st day of previous month	With Proof of Loss of Coverage. The request must be included in the opportunity description.
21st to 31st (inclusive) of the month	According to option selected	1st day of the following month 1st day of the 2nd month 1st day of the 3rd month	Without Proof of Loss of Coverage.
	Backdating	1st day of current month	With Proof of Loss of Coverage. The request must be included in the opportunity description.
		1st day of previous month	With Proof of Loss of Coverage. The request must be included in the opportunity description.

3.7. Premium for new business

Premiums are always deducted on the 1st of each month by way of pre-authorized debit or credit card.

With or without previous coverage		
Issuing Date	**Effective Date of the Policy**	**1st Premium Withdrawal**
1st to 20th (inclusive) of the month	1st day of the previous month (Backdating)	3 premiums, on the 1st day of the following month
	1st day of the current month	2 premiums, on the 1st day of the following month
	1st day of the following month	1 premium, on the 1st day of the effective month
21st to 31st (inclusive) of the month	1st day of the previous month (Backdating)	4 premiums, on the 1st day of the 2nd effective month
	1st day of the current month	3 premiums, on the 1st day of the 2nd effective month
	1st day of the following month	2 premiums, on the 1st day of the 2nd effective month
	1st day of the 2nd or 3rd following months	1 premium, on the 1st day of the effective month

Please note that the first premium amount and deduction date is indicated in the welcome email sent to the applicant.

3.8. Internal replacement of an existing contract

Notice of replacement of contract	For Quebec clients, a notice of replacement is required when they intend to replace an existing contract. A notice of replacement is not a cancellation request of the existing contract. The client must submit a cancellation request for the existing contract.
Effective date	Following the acceptance of the internal replacement, the effective date of the new contract will be the 1st of the following month to avoid any interruption of coverage, and we can waive the waiting periods where applicable.

3.9. Documents sent by the Insurer

The contract is sent by email as follows:

		Recipient	CC
Contracts	**Quick Issue contract**	Applicant	Advisor
	Underwriting offer	Advisor	N/A
	Contract with underwriting decision 'Accepted standard'	Applicant	Advisor

3.10. Rescission period

Right of examination	A period of 10 days (calendar) from the date of delivery is given to the applicant to review the contract. The contract can be terminated by the applicant with a written, dated, and signed request. The contract is then declared null and void from its effective date, and any premium paid is fully refunded. If claims were made within this period, the plan cannot be terminated as a rescission. The Advisor will be notified and asked to check with the client if they prefer for us to terminate the plan for next month or have them refund the claims we paid.

3.11. Insurance application closure

Insurance application closure	As a result of the situations listed below, the insurance application will be closed and cancelled in our systems. • At the applicant's request (the advisor can send the email as long as the applicant is copied in that email). • If underwriting, issuance or implementation requirements are not received.

4. UNDERWRITING

4.1. Underwriting requirements

4.1.1. Service standards

Underwriting clarifications	• The age used is the age attained by the person to be insured on the date of signing the application. • The Underwriting Department may request additional requirements directly to applicants in certain cases.

4.2. Application validity

If the application process has commenced and the file is put on hold, the application is valid for 90 days. Beyond this period, the application cannot be considered by the insurer and a new one must be submitted.

4.3. Underwriting terminology

The Complete Health and Assured Access plans are subject to medical underwriting.

Jet underwriting	According to the answers provided in the health declaration, the application could be eligible for jet underwriting, meaning that the applicant may not have to go through a full medical underwriting process.
Full underwriting	The application can be approved standard, approved with exclusions, approved with a rating, deferred or declined (for example, depending on medical conditions, or height and weight).
Exclusions	All exclusions are permanent. However, if the pre-existing condition is symptom and treatment free for 12 consecutive months following the effective date of the policy, then the client may request to have the exclusion reassessed.

4.4. List of diseases leading to an auto-decline

The following list of conditions automatically eliminates a person from obtaining the Complete Health plan (Health and Drug benefits) and the Assured Access plan. Please note that this list is not exhaustive. It is used as a guide to help make the best plan recommendation.

- Acromegaly
- AIDS/HIV positive
- Alzheimer's
- Apraxia
- Asbestosis
- Bloom Syndrome
- Bradbury-Eggleston Syndrome
- Cavernous Angioma
- Cystic Fibrosis
- Dementia
- Double Inlet Left Ventricle Syndrome
- Epidermolysis Bullosa
- Heart Failure
- Heart Transplant
- Hemophilia (any type)
- Huntington's Disease
- Insulin dependent Diabetes
- Kennedy's Disease
- Kidney Transplant
- Liver Disease (including Cirrhosis)
- Liver Transplant
- Lung Transplant
- Mastocytosis
- Membranoproliferative Glomerulonephritis (MPGN)
- Multiple Sclerosis
- Muscular Dystrophy
- Myelofibrosis
- Neurofibromatosis
- Osteogenesis Imperfecta
- Parkinson's Disease
- Polycystic Kidney Disease (PKD)
- Posterior Cortical Atrophy
- Prader-Willi Syndrome
- Primary Autonomic Failure (PAF)
- Primary Ciliary Dyskinesia
- Primary Sclerosing Cholangitis
- Pure Autonomic Failure (PAF)
- Wegener's Granulomatosis

4.5. Contracts in underwriting follow-up

All requests for additional medical information will be sent by email directly to the applicant.

4.6. Underwriting decision scenarios

Approved standard	Application will be processed, and policy will be issued and sent to applicant.
Approved with exclusions	The underwriter will send an email to the advisor to inform of the exclusion. The advisor will communicate this decision to their client to see if they wish to continue or not. The advisor will communicate the applicant's response (accepted or declined) and start date, if applicable, by replying to the email from the underwriting team and copying the applicant. The opportunity will be closed after 90 days from the applicant's signature date if we do not get an answer back.
Approved with a premium rating	This applies only on the drug coverage with a premium rating up to 200%. The underwriter will send an email to the advisor to inform of the decision. The advisor will communicate this decision to their client to see if they wish to continue or not. The advisor will communicate the applicant's response to the premium adjustment for drug coverage (accepted or declined) and start date, if applicable, by replying to the email from the underwriting team and copying the applicant. The opportunity will be closed after 90 days from the applicant's signature date if we do not get an answer back.
Deferred	The underwriter will send an e-mail to the advisor to inform of the deferred decision and the requirements for reconsideration. The advisor will communicate the decision to their client. The opportunity will be closed after 90 days from the applicant's signature date. If reconsideration is only possible after 6 months of the initial application date, a new application will be required.
Declined	The underwriter will send an email to the advisor to inform that the application was declined. The advisor will communicate this decision to their client. Opportunity will be closed.

4.7. Reconsidering an exclusion

Under the Complete Health plan, an exclusion can be considered for removal based on the following criteria:

- The policy must have been active for the last 12 consecutive months.
- The condition has resolved completely.
- The insured has remained symptom and treatment free for a period of 12 consecutive months from the policy effective date.
- The request must be made during the time period in which the insured was symptom and treatment free.

If all criteria are met, the applicant can complete and sign the **Individual Health Exclusion Questionnaire form**. To obtain a copy of this form, please contact Info-Partners Health.

*Exclusions cannot be removed on an Assured Access plan as these policies are “dormant” while the client has a group plan.

4.8. Modification request with underwriting

4.8.1. Adding a benefit or upgrading a coverage (Complete Health plan)

A full application form and medical evidence is required if an applicant requests to add the following benefits in a Complete Health plan:

- Drug benefit*
- Travel benefit for clients over age 65 with Health benefit Enhanced
- Critical Illness benefit
- Hospital Cash benefit
- Assured Access benefit**

To **upgrade** the Health and Drug benefits, a full application is required, **unless there is a life change event**.
To obtain a copy of the **Complete Health Application form**, please consult your Salesforce Libraries Tab.

* If the Drug benefit is added within 60 days of the policy being issued, the client must complete a **Complete Health Personal Health Plan Change form** and a **Supplemental Statement of Health**.

** If adding the Assured Access benefit, medical underwriting is not required within 12 months of the policy being issued if the client has drug coverage on the plan.

The **Complete Health Personal Health Plan Change form** can be obtained from your Salesforce Libraries Tab. To obtain a copy of the **Supplemental Statement of Health**, please consult Info-Partners Health.

4.8.2. Adding a dependent (Complete Health plan)

Newborn child	If added within 60 days from birth:
	• No medical underwriting
	• A signed and dated letter of direction from the applicant is required with the:
	  ○ Name of the newborn
	  ○ Date of birth of the newborn
	
	If added after 60 days from birth:
	• Full medical underwriting with a **Complete Health Application form**

Adopting a child	If added within 60 days from adoption:
	• No medical underwriting
	• A signed and dated letter of direction from the applicant is required with the:
	  ○ Name of the adopted child
	  ○ Date of birth of the adopted child
	  ○ Copy of the adoption documents
	
	If added after 60 days from adoption:
	• Full medical underwriting with a **Complete Health Application form**
	• Copy of the adoption documents

Spouse* by marriage	If added within 60 days from marriage: • No medical underwriting • A copy of the marriage certificate is required If added after 60 days from marriage: • Full medical underwriting with a **Complete Health Application form** • A copy of the marriage certificate
Common-law spouse*	• Full medical underwriting with a **Complete Health Application form** • A proof of co-habitation is required
Step-child	• Full medical underwriting with a **Complete Health Application form** • A proof of co-habitation or marriage certificate is required
A co-habitant	• Full medical underwriting with a **Complete Health Application form** • A proof of co-habitation is required
Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.

*__Spouse__:
Spouse may opt out of the Drug benefit when being added.
Spouse may opt out of the Critical Illness and Hospital Cash modules when being added.
Critical Illness and Hospital Cash modules will always be underwritten, even when added within the 60-day period.

To obtain a copy of the Complete Health Application form, please consult your Salesforce Libraries Tab.

4.9. Modification request without underwriting

4.9.1. Miscellaneous changes

Change of applicant	Upon receipt of a signed and dated 'Change in applicant' section of the **Complete Health or Guaranteed Acceptance Change form**, or a letter of direction from the current applicant and the new applicant.
Change of address	Change can be made by the applicant through the Member Service Site or mobile app, or by sending an email request indicating the new address.
Change of banking information	Upon receipt of a sign and dated PAD section (found on the **Complete Health or Guaranteed Acceptance Change form**), or a letter of direction, with a void cheque attached to either of the two documents.
Change of credit card information	Change can only be made by the applicant through the Member Service Site or mobile app.
Change of advisor	Upon receipt of the signed and dated **Agent of Record (AOR) form.** The request will be processed within 10 days from the date of receipt. In accepting appointment as a new agent of record, no commission will be paid unless a sale is made to the applicant that results in additional premium to Blue Cross. Also, the new agent of record will be responsible for any commission chargebacks in the events of cancellation.
Correction in date of birth	Upon receipt of a signed and dated letter of direction with proof of correct date of birth. The correct rate is provided to applicant based on the Rate guide. • If the applicant has been paying more than they should, the amounts overpaid will be credited. • If the applicant has not been paying enough, the balance owed will be withdrawn with the next premium.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.9.2. Life change events

The Health benefit and Drug benefit that were already included in the Complete Health plan can be upgraded, without medical underwriting, **within 60 days of a life change event**.

Adding a spouse or child	Health and Drug benefits can be upgraded when adding a spouse or child (growing family): • A spouse through marriage (copy of marriage certificate is required) • A child through birth or adoption (copy of adoption document is required)
Removing a spouse or child	Health and Drug benefits can be upgraded when removing a spouse or child if they no longer meet the definition of a dependent: • A child aged 21-25 who no longer attends school full-time, or aged 26 • Separation of a spouse (signed request is required) • Death of a spouse or child (copy of death certificate is required)
Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.

To upgrade health and drug benefits **within 60 days** of a life change event, the applicant must complete the **Complete Health Personal Health Plan Change form** or send a signed and dated letter of direction with detailed information.

To upgrade health and drug benefits **after 60 days** following a life change event, a **Complete Health Application form** with **underwriting** will be required.

Benefits can only be upgraded if they were initially part of the plan, not added.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.9.3. Adding or Upgrading Dental benefit (Complete Health plan)

Required information	**Complete Health Personal Health Plan Change form** or a signed and dated letter of direction or email which includes: • ID number • Policy number • Details of addition or upgrade • Effective date of addition or upgrade (one calendar month notice required) • New premium that was quoted for the modification
Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.
Re-enrolment of the benefit	If the applicant removes the Dental benefit: • They can re-enroll at any time. • The waiting periods will not be waived even if they re-enroll within the same calendar year. • The waiting periods will be waived **only** if they can submit proof that they were covered for the Dental benefit under another contract during this period. If the applicant re-enrolls within the same calendar year, the benefits will not reset as new. This means that previous claims for services rendered within that calendar year will continue in the re-enrolment.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.9.4. Upgrading Drug or Health benefits, or adding Assured Access benefit (Complete Health plan)

The following benefits can be modified on the Complete Health plan without medical underwriting:

Drug benefit	Can be upgraded within 60 days of the policy being issued
Health benefit	Can be upgraded within 60 days of the policy being issued
Assured Access benefit	Can be added within 12 months of the policy being issued if the client has drug coverage. Otherwise, a full medical underwriting will be required.

Required information	• **Supplemental Statement of Health** (for upgrading Health and Drug benefits)
	• **Complete Health Personal Health Plan Change form** or a signed and dated letter of direction or email which includes:
	  ○ ID number
	  ○ Policy number
	  ○ Details of addition or upgrade
	  ○ Effective date of addition or upgrade (one calendar month notice required)
	  ○ New premium that was quoted for the modification

Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.

The **Complete Health Personal Health Plan Change form** can be obtained from your Salesforce Libraries Tab. To obtain a copy of the **Supplemental Statement of Health**, please consult Info-Partners Health.

4.9.5. Adding Drug benefit (ages 65 and over) or Travel benefit, or adding a dependent (Guaranteed Acceptance plan)

Required information	**Guaranteed Acceptance Change form** or a signed and dated letter of direction or email which includes: • ID number • Policy number • Name of dependent (if adding a dependent) • Date of birth (if adding a dependent) • Details of addition • Effective date of addition (one calendar month notice required) • New premium that was quoted for the modification
Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.
Re-enrolment of the benefit	• Drug benefit: This benefit is mandatory with the Guaranteed Acceptance plan and is optional from age 65. However, if the client requests to cancel the Drug benefit, it cannot be re-added to the plan, unless approved by Blue Cross. • Travel benefit: If removed, this benefit cannot be re-added to the plan.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.9.6. Downgrading coverage, removing a benefit, or removing a dependent from a policy

Required information	**Guaranteed Acceptance Change form** or **Complete Health Personal Health Plan Change form** or a signed and dated letter of direction or email which includes: • ID number • Policy number • Name of dependent (if removing a dependent) • Date of birth (if removing a dependent) • Details of downgrade or removal • Effective date of downgrade or removal (one calendar month notice required) • New premium that was quoted for the modification
Effective date of modification	All changes are effective on the 1st of each month. A month is required from receipt of the request.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.10. Special modification request with or without underwriting

4.10.1. Overage dependents

Clients will receive a letter approximately 60 days in advance of a child's termination (i.e., age 21). The letter outlines the following options for the child to continue coverage.

- Disabled child* (also called a Special dependent)
- Student**
- Roll-overs (considered a new sale and application)

Status	Plan	Requirements
Disabled child* or Student	Guaranteed Acceptance	If we are notified within 60 days from the child's 21st birthday: • Child will be re-added without any waiting periods If we are notified after 60 days from the child's 21st birthday: • Waiting periods will apply for the child
Disabled child* or Student	Complete Health	If we are notified within 60 days from the child's 21st birthday: • Child will be re-added without any medical underwriting If we are notified after 60 days from the child's 21st birthday: • Full medical underwriting
Roll-overs	Complete Health	If child is not disabled or a student: • A new **Complete Health Application form** should be submitted within 60 days from the child's 21st birthday

***Disabled child**: A child is considered to be mentally or physically disabled if they are incapable of engaging in any substantially gainful activity and are financially reliant on the applicant for care, maintenance and support due to this disability.

****Student**: A person who is under age 26 and is attending an accredited educational institution, college or university on a full-time basis.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

4.10.2. Child roll-overs

Children who no longer qualify as dependents of the policy under which they are covered (parent's plan) may roll over to their own individual plan (**same product**). Child roll-overs apply only to underwritten plans.

To qualify for a roll-over, the request must be made **within 60 days of being terminated** and a new application is required.

Add Dental benefit	If the parent's Complete Health plan does not currently have the Dental benefit, it can be added without medical underwriting. However, waiting periods will apply if not added within 60 days of being terminated.
Increase or add coverage	To increase or add coverage that was not on the parent's Complete Health plan, medical underwriting will be required. Exception: If Drug coverage was included in the parent's plan, the child can select any level of Health, Drug or Dental coverage.
Reduce or remove coverage	The child can request to have coverage reduced or removed.
Add Assured Access module	If the parent's plan does not currently have the Assured Access module, it can be added within 12 months of the effective roll-over date, without medical underwriting.
Assured Access plan	If the child is currently obtaining group coverage, they may roll-over to an Assured Access plan within 60 days of being terminated (if plan was underwritten and now on group coverage).

- If applicable waiting periods have already been satisfied, no new waiting periods will be applied.
- Existing exclusions will remain.
- Claim history, maximums and frequency will follow the insured when rolling over.

4.10.3. Splits

A spouse may obtain their own individual plan (**same product**). This is usually due to divorce or separation. Splits apply to both Complete Health and Guaranteed Acceptance plans.

To qualify for a Split, the request must be made **within 60 days of being terminated** and a new application is required.

Increase or add coverage	To increase or add coverage, medical underwriting will be required, except for Dental (waiting periods apply).
Reduce or remove coverage	The spouse can request to have coverage reduced or removed.

- If applicable waiting periods have already been satisfied, no new waiting periods will be applied.
- Existing exclusions will remain.
- Claim history, maximums and frequency will follow the client when rolling over.

4.10.4. Special dependents

If a disabled child cannot obtain full personal health benefits, they can be considered a special dependent. Blue Cross may require from the applicant a **Special Dependent Questionnaire** completed by the applicant and their physician) as often as reasonably necessary. This means, if a dependent is approved as a special dependent, the approval can be permanent or temporary with future reassessment.

Dependent is already part of the parental plan or has been removed from the parental plan within the last 60 days	Dependent will be assessed if they qualify as a special dependent. Required documentation: ○ **Special Dependent Questionnaire** Possible decision on special dependent status: ○ Approved as a special dependent ○ Approved as a regular dependent but not as a special dependent
Dependent is not currently on the plan or applies over the 60 days past termination from the plan	<u>Dependent is under age 21</u> Dependent will go through medical underwriting. If the dependent qualifies for coverage, they may be asked to complete a second assessment for special dependent status at the discretion of the medical underwriter. Required documentation: ○ **Completed Health Application form** ○ **Special Dependent Questionnaire**, at medical underwriter's discretion Possible decision outcomes on special dependent status: ○ Approved as a special dependent ○ Approved as a regular dependent but not as a special dependent <u>Dependent is between the ages 21-26</u> Dependent will go through medical underwriting and will be assessed as an overage dependent. If the dependent qualifies for coverage as a student, they may be asked to complete a second assessment for special dependent status at the discretion of the medical underwriter. Required documentation: ○ **Completed Health Application form** ○ **Special Dependent Questionnaire**, at medical underwriter's discretion Possible decision outcomes on special dependent status: ○ Approved as a special dependent ○ Approved as an overage dependent but not as a special dependent

	Dependent is over age 26 Dependent will go through medical underwriting. If the dependent qualifies for coverage, they will be asked to complete an assessment for special dependent status. Required documentation: ○ **Completed Health Application form** ○ **Special Dependent Questionnaire** Possible decision outcomes on special dependent status: ○ Approved as a special dependent ○ Declined as a special dependent but can have their own individual plan

Note: We **do not** accept government letters indicating that the individual is approved as a disabled dependent for tax purposes. The government's criteria may not be the same as ours, therefore we cannot base our decision on their approval letter alone.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

5. CONTRACT ADMINISTRATION

5.1. Cancelling a policy

Required information for a cancellation request	To cancel a policy, the applicant must submit a signed and dated request. The following information must be included in the request: • ID number • Policy number • First and last name of applicant • Cancellation reason (recommended but not mandatory) These requests must be sent before the 1st of the month to be processed for the end of the month / 1st of the next month (one calendar month's notice). When a cancellation request is received directly from the applicant, an email notification will be sent to you. We will grant you 10 business days to clarify the situation with your client. For the Guaranteed Acceptance plan, once the applicant has cancelled, they are not eligible to re-apply for another Guaranteed Acceptance plan within 24 months unless they can provide proof of losing group benefits. **Applicable to all our products**: If the applicant cancels their policy, they have the right to reinstate their plan within 30 days of the cancellation without having to fill out a medical questionnaire.
Cancellation upon death of the insured	A death certificate must be sent to the insurer to terminate the policy of an insured who is deceased. If applicable, we will refund to the Estate the premiums paid since the date of death.
Cancellation by the insurer for non-payment	If one month's premium is unpaid the policy will lapse and a double deduction will be taken from the client's account in the following month. Client will receive a missed payment letter and will not have access to the MSS or mobile app until premium is paid and the policy is automatically reinstated. If a second consecutive premium is unpaid, the policy will automatically be terminated. A missed payment letter is sent to the client at the end of the 2nd month advising of the termination and giving the client 30 days to reinstate. Overdue premiums must be received by the end of the 3rd month to be eligible to reinstate without medical evidence (in the case of the Complete Health plan). You will receive copies of the missed payment letters sent to your client, except for the initial billing notice, so you can follow up with your client to keep the policy from being cancelled.

5.2. Reinstatement request

If a policy has lapsed following non-payment of the premium, it can be reinstated at the Insurer's discretion, according to the following guidelines.

General requirement	To reinstate a policy, we will require all the outstanding premiums to be paid via credit card or online banking.
Complete Health plans	For Complete Health plans, the policy can be reinstated up to 60 days of the date of lapse without medical evidence. If the 60 days has passed, it will no longer be a reinstatement. Instead, it will be considered as a new sale, that is, we will require a new **Complete Health Application form** and a full **medical questionnaire** to be completed. Waiting periods for applicable benefits will apply in this situation.
Guaranteed Acceptance plans	For Guaranteed Acceptance plans, the policy may be reinstated within 2 years of the date of lapse upon written application satisfactory to Blue Cross and payment of all overdue premiums.

Under the provisions of the policy, the insurer reserves the right to require proof of the insured's medical condition when a medical questionnaire is completed.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

5.3. Interplan transfer

This procedure is offered to Blue Cross individual policy holders from another province who are moving to Ontario or Quebec and wish to continue with an individual health insurance without having to go through the underwriting process.

There are two possible scenarios:

Client holds an underwritten plan	The Advisor can offer their client a Complete Health plan and bypass the underwriting process and the waiting period. Exclusions of the previous contract, if applicable, are maintained.
Client holds a plan without underwriting and wishes to subscribe to a new plan without interruption of coverage	The Advisor can offer their client a Complete Health plan or a Guaranteed Acceptance plan and bypass the waiting periods. However, for the Complete Health plan, underwriting is required.

In any case, Advisors must offer a similar plan and the client must contact you within 90 days following the termination date of the other Blue Cross health contract.

5.3.1. Procedure

1. Advisor calls Info-Partners Health	Preliminary eligibility validation • The applicant must have contacted OHIP or RAMQ to start the process of obtaining the provincial health coverage. • The applicant canceled their other Blue's plan and can provide the termination date of the plan. • The request must be made prior to the termination date of the former plan or within the 90 days following the termination. The Advisor provides Info-Partners Health with the information needed to complete the Interplan Transfer form.
2. Advisor will receive a follow-up call from Info-Partners Health	• Info-Partners Health will confirm the applicant's eligibility to the Advisor. • The Advisor must complete a manual application of the **Complete Health Application Form**.
3. Advisor sends application to Info-Partners Health	• The Advisor must return the application through the secured file transmission form under the request type 'Everything related to your contract': o Ontario: https://on.bluecross.ca/depot o Quebec: https://qc.bluecross.ca/depot • Info-Partners Health will send the application to the Administration department for processing.

Please note that the Advisor must be licensed in the province of residence in which the plan transfer is done (Ontario or Quebec) and needs to be contracted with Ontario Blue Cross or Quebec Blue Cross.

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

5.4. Three-month plan freeze

Clients can apply for a three-month plan freeze* by submitting a signed and dated written request.

The criteria that applicants must meet to request the three-month plan freeze are:

- Policy must be active for the last 6 consecutive months.
- Premiums must be paid up-to-date.
- Claims will not be paid during the period in which the plan is suspended, and claims incurred during the suspension will not be paid once the plan is re-activated.
- The three-month suspension will not be extended.
- The plan suspension can only be used once per lifetime.
- Waiting periods will be on hold during the plan suspension.
- All terms and conditions of the policy, including allowable maximums, exclusions and limitations will resume once the plan is re-activated.

*Freeze cannot be offered to clients holding an Assured Access plan.

5.5. Activating Assured Access plan

When activating the Assured Access plan or the Complete Health plan from Assured Access, the client must **notify us within 60 days of losing group coverage***.

The **Assured Access Change form** must be completed, and a proof of group coverage loss will be required.

To obtain a copy of the Assured Access Change form, please contact Info-Partners or consult your Salesforce Libraries Tab.

***Failure to provide this notification within 60 days will invalidate the policy and the client will never be able to activate this plan again in the future.**

To obtain a copy of these forms, please consult your Salesforce Libraries Tab.

5.6. Renewal

Renewal notice	No renewal notices are sent to the client. The policy remains active as long as premiums are paid, until the client chooses otherwise.
Rate adjustment letters	A rate adjustment letter is sent to the applicant sixty (60) days prior to their contract renewal date. A rate adjustment letter is not sent if the applicant's rate increase is due to an age band change, in which case they would receive an age band letter instead.
Monthly report on contracts to be renewed	A report indicating the contracts still in force but up for renewal the following month is available on Salesforce under the Reports Tab, in a section entitled 'Next Month Renewal Report'.

5.7. Tax receipt

Tax receipt	No later than February 28 of each year, the insurer issues a tax receipt for the portion of premiums paid that are eligible for the medical expense tax deduction. This document can be accessed via the Member service site (MSS).

6. CLAIMS

6.1. Service standards

Processing time	Our target is to process at least 80% of all documents received within a maximum of 5 working days.

6.2. Submitting a claim

Mobile app	New clients must download the **Blue Cross Mobile** (Medavie, Ontario and Québec) app on their mobile device. The app is available for Android (Google Playstore) & Apple (Apple Store) users.
Member service site portal (MSS)	Clients can login to the Member Service Site: For Ontario: https://www.medaviebc.ca/en/ontarioplans/members For Quebec: https://www.medaviebc.ca/en/quebecplans/members
ePay (Provider online claims)	Health providers who are registered for online billing can submit the claim electronically to Blue Cross on behalf of the client. The client will pay the health provider only the portion of the claim that is not covered by the benefit.
Documents transmission	Clients who do not have access to the mobile app or member service site can submit their claims by mail or through the secured file transmission form: Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot

6.2.1. Using the Mobile app or Member service site (MSS)

Function and use	The mobile app and MSS provides access to: • View claims history • Submit claims • View coverage and benefits • View plan usage • View Digital Identification Card • Find a registered health practitioner • Modify personal information • Modify banking information
Requirements to create an account	On the first visit, the client will need to create their account by entering the following information: • Identification Number indicated on the Digital Identification Card (also provided in the welcome email sent with the policy) • Policy Number indicated on the Digital Identification Card (also provided in the welcome email sent with the policy) • Date of Birth • Email

6.2.2. Information required for submitting a claim

ePay is the easiest way to submit claims. ePay can be used for most services under the Health, Dental and Drug benefits.

However, where ePay is not available and the client must submit their claims by other means, the receipts must include the letterhead of the person or company that provided the service and clearly indicate the following:

- Patient's name
- Service date(s)
- Service description
- Cost of each service rendered
- Healthcare professional's name
- Type of healthcare professional
- Healthcare professional's license or registration number

6.3. Health benefit

Examples of fees covered	• Some services provided by health practitioners • Prescription eyeglasses and contact lenses • Medical devices and supplies **It is very important to refer to the policies for the details of the coverage as this is subject to change.**
Restrictions	**Pre-existing condition** Any pre-existing condition may be excluded depending on the terms of the policy. **Exclusion specific to the insured** If the contract specifies an exclusion specific to the insured, the expenses for that exclusion are not eligible. It is critical that any suspected or diagnosed conditions are fully disclosed at the time of application, otherwise the contract could be cancelled as of its issue date for a claim that was otherwise valid. **Massage therapy expenses** To be reimbursable, a signed doctor's prescription is always required and must be renewed annually. **Purchase or rental of medical equipment and supplies** For the purchase or rental of medical equipment, prostheses, orthotics or any other medical supplies, a signed doctor's prescription is always required and has to be submitted for the insurer's pre-approval. **Claim deadline** Claims must be submitted within 12 months of the service date.

6.4. Dental benefit

Coverage	Eligible expenses are reimbursed according to: • The fees of the provincial dental association mentioned in the policy. • The previous year's guide for the year of services rendered or the current year's guide. • The coverage level selected by the applicant, where applicable
Treatment plan	For any dental treatment, it is recommended that the insured send us a detailed treatment plan that will be subject to the insurer's pre-approval. As soon as the treatment plan has been analyzed, we will send a communication to the insured indicating the amount that will be payable.
Restrictions	Eligible expenses are reimbursable up to the maximum amount provided for in the policy. Orthodontic services are limited to insureds 18 years of age and under. **It is very important to refer to the policy for the details of the coverage.**

6.5. Drug benefit

Coverage	Reimbursement of eligible expenses is limited to: • The coverage level selected by the applicant, where applicable • The dollar, quantity or frequency maximums mentioned in the policy. The Drug benefit in Quebec is complementary to RAMQ coverage or a group plan offering the drug benefit where applicable.
Restrictions	**Pre-existing condition** Any pre-existing condition may be excluded depending on the terms of the policy. **Exclusion specific to the insured** If the contract specifies an exclusion specific to the insured, the expenses for that exclusion are not eligible. **Special Authorization** Certain eligible drugs may require Special Authorization before the prescription is covered. **Days Supply** 100-day maximum supply (1 month supply may apply to some drugs). **Dispensing Fee Frequency Limit (Ontario only)** When Blue Cross determines an eligible drug to be a maintenance drug that can reasonably be dispensed as a 3-month supply, Blue Cross will pay up to five dispensing fee charges per maintenance drug within a 12-month period. If an insured person chooses to fill their prescription more frequently, they will be responsible for paying any additional dispensing fees for the maintenance drug.

6.6. Critical Illness benefit (Complete Health plan)

Coverage	To be eligible for payment, the insured's medical condition must meet the definition of one of the covered conditions, and survive the onset of the covered condition for a period of 30 days. Benefit amounts: • Applicant $25,000 • Spouse $25,000 • Dependent Child $10,000
Covered conditions	• Alzheimer's Disease • Blindness • Burns • Coma • Deafness • Life Threatening Cancer • Loss of Speech • Major Organ Failure • Major Organ Failure requiring transplant • Motor Neuron Disease • Multiple Sclerosis • Paralysis • Parkinson's Disease • Senile Dementia • Severe Heart Attack • Severe Stroke Please refer to the policy for the definition of each covered condition.
Restrictions	**Pre-existing condition** A covered condition will be excluded if it was a pre-existing condition based on the terms of the policy. **Covered conditions** All covered conditions must result from an illness or disease in order to be eligible for coverage with the exception of burns. **Newborns** Dependent children are not insured until 15 days of age. **Waiting period** The insured must be covered under the contract for 90 days before being eligible for this benefit. **Maximum benefit amount** Benefit amount is payable once per lifetime for each insured. **Termination of coverage** For applicant and spouse, on the earlier of the following dates: • The end of the month prior to age 65, or • Upon termination of the contract • For spouse, when the spouse no longer meets the definition of spouse under the policy For dependent child, on the earlier of the following dates: • When neither the applicant or applicant's spouse, if applicable, is covered for this Benefit, or • When the dependent no longer meets the definition of dependent under the policy, or • Upon termination of the contract.

6.7. Hospital Cash benefit (Complete Health plan)

Coverage	If an insured is confined to a hospital in Canada on an inpatient basis undergoing active treatment, Blue Cross will pay: • Under age 65 - $100 per day up to 100 consecutive days of hospitalization per calendar year • Age 65 and over - $100 per day up to 30 consecutive days of hospitalization per calendar year
Restrictions	**Pre-existing condition** A covered condition will be excluded if it was a pre-existing condition based on the terms of the policy. **Start of benefit payments** • 1st day of hospitalization due to an accident • 4th day of hospitalization due to sickness • 8th day of hospitalization due to maternity Day of admission will be counted as 1 day but day of discharge will not be counted unless it is also the day of admission. **Newborns** Benefit will not apply to the newborns until released from the hospital following birth. **Termination of coverage** For spouse and dependent child, on the earlier of the following dates: • When they no longer meet the policy definition of dependent • Upon termination of the entire contract • For dependent child, when neither the applicant or applicant's spouse is covered for this benefit under the contract

6.8. Travel benefit

The Travel benefit is offered as follows:

- A mandatory benefit on the Complete Health plan for Health benefit Enhanced and becomes optional at age 65
- An optional benefit on the Guaranteed Acceptance plan
- An optional benefit on the Assured Access standalone plan

Coverage	Benefits will be provided in the event of an accident or an unexpected or sudden illness that occurs outside the insured's province of residence. Insureds are covered up to $5 million per person per trip. They are also covered for specific number of days per trip depending on their plan: • Complete Health plan – Health benefit Enhanced: **30 days per trip** • Guaranteed Acceptance plan: **17 days per trip** • Assured Access standalone plan: **30 days per trip**
Examples of fees covered	• Hospital services • Prescriptions and treatments • Medical appliances • Transportation benefits • Return of deceased **It is very important to refer to the policy for the details of the coverage.**
Required information	• All claims and required government forms must be submitted within 4 months of the date of service, otherwise they will become the insured's responsibility. • For claims where the travel assistance provider is not used, original detailed paid-in-full receipts must be sent to Blue Cross to permit coordination of eligible benefits with government health care coverage. • All medically-related claims must include original documents showing the date of service, diagnosis and details of services rendered. If the original documents are not available, copies of such must be stamped "certified copy" and be signed by the facility representative. • The insured must include their Blue Cross policy and ID number on their claim.
Restrictions	**Maximum days per trip** The participant is provided emergency medical travel insurance for an unlimited number of trips up to a maximum of: • 30 consecutive days per trip for the Complete Health plan – Health benefit Enhanced • 17 consecutive days per trip for the Guaranteed Acceptance plan • 30 consecutive days per trip for the Assured Access standalone plan For coverage over these consecutive days, the participant must contact their authorized Blue Cross agent or nearest Blue Cross office. **Blue Cross Travel Assistance** When hospitalization occurs, our Blue Cross Travel Assistance must be contacted prior to admission. Failure to contact Blue Cross Travel Assistance may result in the insured's medical expenses not being eligible, a delay in the settlement of their claim or reduced benefits.

Destination	Telephone
Canada/USA	1-800-361-6068
Mexico	800-062-3174
Dominican Republic	1-800-203-9666
Elsewhere	1-800-7328-7473
Elsewhere, collect	514-286-8411

Blue Cross Travel Assistance reserve the right to direct participants requiring medical treatment to hospitals and physicians that have been selected to provide health care services.

Pre-existing condition
Blue Cross will not pay any benefit or accept any liability for claims relating to a medical condition, illness or injury or related medical condition, illness or injury that has deteriorated or for which a participant has been diagnosed or hospitalized, required medical consultation (other than a routine checkup), or had a change in medication at any time within the:

a. 3 month period immediately prior to the date of departure from the participant's province of residence, if the participant is under age 65;
b. 6 month period immediately prior to the date of departure from the participant's province of residence, if the participant is age 65 or older

7. COMMISSIONS AND CONTRACTING

7.1. Service standards

Return of calls and reply to general emails	1 business day
Renewal of licenses and E&O	3 business days
Contracting request	2 business days once all contracting documents have been correctly completed
Book of business transfers	3 business days once all contracting documents have been correctly completed

7.2. Role of the Commissions and Contracting Department

The Commissions and Contracting Department is responsible for managing operations and contracts with our partners and Advisors.

The Commissions and Contracting Department:

- Creates and updates advisor profiles
- Updates, terminates distribution accounts
- Processes, handles commissions and overdue accounts
- Follows up on the renewal of advisors' licenses and E&O
- Book of business transfer

To become a contracted advisor, to get more information, or to change your existing contract, contact the Commissions and Contracting Department. Refer to the "Contact Us" section.

You will be asked a series of questions each time you call to verify your identity and protect the confidentiality of our advisors' files.

7.3. Submitting a distribution request

7.3.1. Requirements

Required documents	• Copy of a valid license • Copy of liability insurance • A void cheque • Completed and signed Representative's Agreement • Representative Data Sheet • Quebec Enterprise Number (NEQ) when legal entity (Quebec only)
Documents transmission	Documents must be sent through the secured file transmission form under 'Distribution Agreement' request type. Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot

7.4. Required certificates

To be able to sell our products, you must have the license required by your province and brokerage.

Quebec brokerage firm	Valid license for insured persons issued by Autorité des marchés financiers
Quebec independent advisor	Valid license for insured persons issued by Autorité des marchés financiers
Ontario brokerage firm	Valid insurance agent license issued by the Financial Services Commission of Ontario
Ontario independent advisor	Valid insurance agent license issued by the Financial Services Commission of Ontario
Licenses not accepted	Damage insurance licenses are not accepted

7.5. Liability insurance

Professional liability insurance	Proof of professional liability insurance coverage*. *This insurance grants advisors' coverage against the consequences of their civil liability in case of error, fault, negligence, or omission committed in the pursuit of their professional activities. Professional liability insurance is required because it protects both professionals and their clients.

7.6. Right of distribution renewal

Right of distribution renewal	The renewal of the right of distribution* is automatic. *An advisor who does not submit new business and has no enforced listing for more than 12 months will have their account reviewed for possible termination.
Valid license	Hold and maintain a valid license and comply with the applicable laws of the province in which you wish to operate. Submit proof of the validity of the required licenses, certificates, and registrations annually*. *Failing to provide the required documents by the set deadline would delay your compensation payments.
Professional liability insurance	Hold and maintain valid liability insurance (E&O). Provide proof of the required professional insurance coverage on an annual basis*. *Failing to provide the required documents by the set deadline would delay your compensation payments.

7.7. Updating a file

Updating contact information	To change an address, telephone number, or email address, email a request to Commissions and Contracting.
Changing banking information	Documents must be sent through the secured file transmission form under 'Distribution Agreement' request type. Ontario: https://on.bluecross.ca/depot Quebec: https://qc.bluecross.ca/depot Be sure to include: • **Bank account change form** duly completed and signed • A copy of a void cheque for the new bank account • Your distributor number

To obtain a copy of the Bank account change forms, please consult Info-Partners Health.

7.8. Tax statements

Eligibility	Only independent advisors that have been paid commissions during the year in question will receive a T4-A slip and/or RL-1 slip (Quebec). *The minimum threshold is $500.
Non-eligible	No T4-A or RL-1 slips are issued for: • Corporations • LLCs • Partnerships • Registered businesses • Advisors whose commissions are paid to a legal person that previously had a distribution agreement with or Ontario Blue Cross
Issuance	Receipts for the fiscal year in question are issued to the bank account owner no later than February 28, as required by law.

7.9. Account statements

Access to reports	Account statements are available in Salesforce for Blue Cross Health products. Advisors can log in and select the Reports tab which shows their book of business, commission, cancellations, etc. You can apply filters to refine the search results.
Commission rates and frequency	Commission rates and frequency are set out in your Distribution Agreement. Rates are based on the products sold, among other factors, and the percentage varies with the age of the contract.
Commission payment	Commissions are payable via direct deposit to a designated bank account. Amounts owing can be paid by cheque within 60 days of the date of your account statements to the following address: Quebec Blue Cross Commissions and Contracting 1981 McGill College Avenue, suite 105 Montreal, Quebec H3A 0H6

7.10. Reports

Commissions Tab	Individual Commission Invoices, Payment Remittances and Credit Memos are available in Salesforce under the Commissions Tab: • Statements starting with *1-FS* are *Commission Invoices (*detailed per account/contract) • Statements starting with *5-FS* are *Credit memos* (chargeback for one account/contract) • Statements starting with *6-00* are *Payment Remittances* (direct deposit)
Reports Tab	Detailed reports, that can be customized based on dates, are available in the Reports Tab: • Commission Invoice and Credit Memo reports • Payment Remittance reports • First year cancellation reports • Next Month Renewal Report • Book of business details