New Nouveau Brunswick

MEDAVIE BLUE CROSS™

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-877-849-8509 FAX: 1-800-644-1722
life_claims@medavie.bluecross.ca

TERMINAL ILLNESS CLAIM FORM

EMPLOYEE STATEMENT

Employee's Name: _____

Policy Number: **19800-000** Date of Birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____

I, _____ , wish to apply for the Terminal Illness Benefit under my group plan.

EMPLOYEE AUTHORIZATION

I hereby certify that the above information is correct to the best of my knowledge and belief. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health to give Medavie Blue Cross any such information.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, if consent is withheld or revoked, the coverage may be denied or rescinded.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 to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1-800-667-4511 or medaviebc.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.

Dated at _____ this _____ day of _____ year _____

Signature of Witness: _____

Signature of Employee: _____
(If under 18 years of age, the signature of the policyholder/parent/legal guardian is required.)

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

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ATTENDING PHYSICIAN'S STATEMENT TERMINAL ILLNESS CLAIM FORM

PART 1: PATIENT AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I hereby authroize the release to my insurer of any information in respect of this application.

Signature: _____ Date: _____

PART 2: ATTENDING PHYSICIAN'S STATEMENT

Diagnosis:

A) Primary: _____

_____

B) Secondary: _____

_____

C) Additional Conditions or Complications: _____

_____

_____

_____

Date Symptoms Appeared: _____

In your opinion, what is your patient's life expectancy? (mandatory) _____

_____

_____

Please provide any information that would be relevant for this application: _____

_____

_____

_____

_____

_____

Physician's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Fax Number: _____

Signature: _____ Date: _____