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

CLAIM FOR CRITICAL ILLNESS BENEFIT

New Nouveau Brunswick

EMPLOYER'S STATEMENT

Employee's Name: _____

Policy Number: **19500 (AD&D) / 99525-000 (Optional CI)** Identification Number: _____

Effective Date of Employee's Coverage With Medavie Blue Cross (DD/MM/YYYY): _____ Date Employed (DD/MM/YYYY): _____

Effective Date of Employee's Coverage for Basic Critical Illnes (DD/MM/YYYY): _____ for Optional Critical Illness, effective date is determined by Medavie Blue Cross

Is coverage still in force? ☐ Yes ☐ No If No, date cancelled (DD/MM/YYYY): _____

Reason the coverage was cancelled: _____

Is employee actively at work? ☐ Yes ☐ No If No, what is date last worked (DD/MM/YYYY): _____

If No, please explain the reason this employee discontinued work: _____

Employer: _____ Signature: _____

Date (DD/MM/YYYY): _____ Title: _____

CLAIMANT'S STATEMENT

Claimant's Name: _____ Date of Birth (DD/MM/YYYY): _____

Address: _____

City: _____ Postal Code: _____ Telephone Number: _____

Claimant's relationship to the employee ☐ Employee ☐ Spouse ☐ Dependent

Date of onset of condition (DD/MM/YYYY): _____ Have you had this condition before? ☐ Yes ☐ No When? (DD/MM/YYYY): _____

Describe the condition: _____

Please give name(s) of all medical practitioners who treated you for this condition: _____

Name(s) of hospital(s) in which you were treated: _____

CLAIMANT 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 Claimant: _____
(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.

DIRECT DEPOSIT AUTHORIZATION

ATTACH SAMPLE CHEQUE MARKED "VOID" HERE

Name of Bank: _____

Bank Address: _____

Financial Institution Number: _____ Branch Number: _____

Account Number: _____

I request my benefits be paid through electronic funds transfer (direct deposit) into this account. I may cancel this authorization at any time by giving written notice to Blue Cross.

Signature: _____ Date (yyyy/mm/dd): _____

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New Nouveau Brunswick

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS BENEFIT

Part 1: Patient Authorization

Patient's Name	Date of Birth DD / MM / YY
I hereby authorize the release to my insurer and my policyholder of any information in respect of this application.	
Patient's Signature:	Date DD / MM / YY

Part 2: Attending Physician's Statement

Diagnosis:

A) Primary

B) Secondary

C) Additional conditions or complications

Date symptoms appeared DD / MM / YY	Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, give dates and details:

Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition.

DD / MM / YY

Date of last treatment for this condition, if different from above. DD / MM / YY	Date of last treatment for this condition. DD / MM / YY
Was patient in hospital? ☐ Yes ☐ No	Name and address of hospital:

Date of hospital treatment

Outpatient: _____ DD / MM / YY **OR** Inpatient Admission: _____ DD / MM / YY Discharge: _____ DD / MM / YY

Surgical treatment, if any: Details:

Date: _____ DD / MM / YY

Are you aware of other physician(s) who treated this patient due to this present condition? ☐ Yes ☐ No
If yes, please give name(s) and address(es):

Do you believe the patient is competent to endorse cheques and direct the use of proceeds? ☐ Yes ☐ No

Please summarize your patient's medical history (attach copies of tests administered including the results of any relevant clinical findings).

List all objective findings:

List all subjective findings:

Please indicate how activities of daily living are affected by this condition.

Eating _____

_____

Dressing _____

_____

Bathing _____

_____

Ambulation _____

_____

Toileting _____

_____

Cardiac functional capacity (if applicable).
(Canadian Cardiovascular Society)

☐ Class 1
No limitations

☐ Class 2
Slight limitations

☐ Class 3
Marked limitations

☐ Class 4
Complete limitations

Please forward results of stress tests, angiogram, etc.

Please outline your prognosis for this patient (refer to the list of critical illnesses):

Remarks:

Physician's Name (Print)

Address

Telephone No.
( )

Signature

Date