

EMPLOYER'S STATEMENT

Employee's Name: _____
 Policy Number: **19500** 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 Conditions (DD/MM/YYYY): _____
 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 When? (DD/MM/YYYY): _____
 No
 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): _____

**ATTENDING PHYSICIAN'S STATEMENT
CRITICAL CONDITION BENEFIT**

Part 1: Patient Authorization

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

Part 2: Attending Physician's Statement

Diagnosis:	
A) Primary	
B) Secondary	
C) Additional conditions or complications	
Date symptoms appeared _____ <small>DD / MM / YY</small>	Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates and details:
Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition. _____ <small>DD / MM / YY</small>	
Date of last treatment for this condition, if different from above. _____ <small>DD / MM / YY</small>	Date of last treatment for this condition. _____ <small>DD / MM / YY</small>
Was patient in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of hospital:
Date of hospital treatment	
Outpatient: _____ <small>DD / MM / YY</small>	OR Inpatient Admission: _____ <small>DD / MM / YY</small>
Discharge: _____ <small>DD / MM / YY</small>	
Surgical treatment, if any:	Details:
Date: _____ <small>DD / MM / YY</small>	
Are you aware of other physician(s) who treated this patient due to this present condition? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 conditions):

Remarks:

Physician's Name (Print)

Address

Telephone No.

()

Signature

Date