MEDAVIE BLUE CROSS™

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New Nouveau Brunswick

CLAIM FOR ACCIDENTAL INJURY

Instructions: 1) Complete this side of the form 2) Arrange for the doctor to complete the reverse side 3) Mail the completed form to Medavie Blue Cross

EMPLOYER'S OR POLICYHOLDER'S STATEMENT

Employee's Name		Policy No. **19500**	Identification No.
Occupation	Employee's last day at work (DD/MM/YY)	Reason for leaving work:	

Dismissed ☐ Disability ☐ Other (specify) ☐
Temporary Layoff ☐ Quit ☐
Layoff ☐ Leave of Absence ☐
Retired ☐

Is this claim due to an occupational injury? Yes ☐ No ☐

Is a claim being made for Workers' Compensation? Yes ☐ No ☐

Do you know of any reason why this claim should not be paid? Yes ☐ No ☐ If yes, give reason:

Administrator's Name _____
Please print

Date _____ Signature _____

CLAIMANT'S STATEMENT

Name	Address	Date of Birth (DD/MM/YY)

Date of Accident (DD/ MM/YY) _____ Time _____ ☐ AM ☐ PM

Where did the accident happen? ☐ Home ☐ Work ☐ Elsewhere (specify) _____

How did the accident happen? Please give complete description.

I am claiming Dismemberment Benefits due to the loss of

I hereby certify that the above information is correct to the best of my knowledge and belief.

Dated at _____ on this _____ day of _____ year____ .

Witness _____ Claimant's Signature _____

Address _____ Address _____

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): _____

Policy No. _____ Identification No. _____

I hereby 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 or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross'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 organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

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

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

Dated at _____ this _____ day of _____ year _____

Signature of Claimant _____ Address _____

Signature of Witness _____ Address _____

PHYSICIAN'S STATEMENT

Patient's Name | Age

1. Date of Accident (DD/MM/YY) | Nature of accident

Was the injury self-inflicted? ☐ Yes ☐ No Describe:

Did the accident occur in the course of the patient's occupation or employment? ☐ Yes ☐ No

Did the loss occur from bodily injury caused solely by external, violent and accidental means? ☐ Yes ☐ No
If no, please give details of contributory causes.

2. Date of first treatment following accident (DD/MM/YY) | Date of last treatment following accident (DD/MM/YY)

Was the patient treated in hospital? ☐ Yes ☐ No | Name of Hospital:

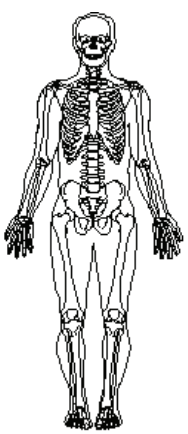
Date of hospital treatment:
Outpatient (DD/MM/YY) **OR** Inpatient Admission (DD/MM/YY) Discharge (DD/MM/YY)

Surgical treatment, if any:

Date (DD/MM/YY) _____ | Details:

Are you aware of any other physician(s) who treated this patient due to this accident? ☐ Yes ☐ No
If yes, please give name(s) & address(es).

If the accident caused the loss of hand, arm, leg or foot, indicate on the chart the level of amputation or loss of use.



Did the accident result in				A. Loss of use of	B. Amputation OR (where applicable)	C. Date of loss (DD/MM/YY)
loss of hand	☐ left	☐ right	☐ both	☐	☐	
loss of foot	☐ left	☐ right	☐ both	☐	☐	
loss of arm	☐ left	☐ right	☐ both	☐	☐	
loss of leg	☐ left	☐ right	☐ both	☐	☐	
loss of thumb and fingers (at or above the first interphalangeal joint)						
thumb #1	☐ left	☐ right	☐ both	☐	☐	
index finger #2	☐ left	☐ right	☐ both	☐	☐	
#3	☐ left	☐ right	☐ both	☐	☐	
#4	☐ left	☐ right	☐ both	☐	☐	
little finger #5	☐ left	☐ right	☐ both	☐	☐	
loss of toes (at or above the first interphalangeal joint)						
big toe #1	☐ left	☐ right	☐ both	☐	☐	
#2	☐ left	☐ right	☐ both	☐	☐	
#3	☐ left	☐ right	☐ both	☐	☐	
#4	☐ left	☐ right	☐ both	☐	☐	
little toe #5	☐ left	☐ right	☐ both	☐	☐	
loss of speech				☐		
loss of hearing	☐ left	☐ right	☐ both	☐	☐	
loss of sight (20/200)	☐ left	☐ right	☐ both	☐	☐	

b) Is the patient
1) quadriplegic ☐ Yes ☐ No
2) paraplegic ☐ Yes ☐ No
3) hemiplegic ☐ Yes ☐ No

Is the loss total and irrecoverable?
☐ Yes ☐ No

Remarks

Physician's Name (Print) | Address

Telephone No. | Signature | Date (DD/MM/YY)

The Patient is responsible for securing this form and for charges made for its completion.