MEDAVIE BLUE CROSS™

APPLICATION FOR CRITICAL CONDITION BENEFIT

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-800-644-1722

EMPLOYER'S STATEMENT

Employee's Name	Policy No.	Identification No.

Effective date of employee's coverage with Medavie Blue Cross (DD / MM / YY)	Employee Class	Does employee have family coverage? ❑ Yes ❑ No	Date Employed (DD / MM / YY)

Effective date of employee's coverage for Critical Conditions (DD / MM / YY)	Is employee actively at work? ❑ Yes ❑ No If no, what is date last worked? (DD / MM / YY) _____
Is coverage still in force? ❑ Yes ❑ No If no, date cancelled (DD / MM / YY) _____ Reason cancelled:	If no, please explain the reason this employee discontinued work:

Employer _____ Signature _____

Date _____ Title _____

CLAIMANT'S STATEMENT

Claimant's Name	Address	Telephone Number ( )

Claimant's relationship to the employee ❑ Employee ❑ Spouse ❑ Dependent	Claimant's Date of Birth (DD / MM / YY)

Date of onset of condition (DD / MM / YY)	Have you had this condition before? ❑ Yes When? (DD / MM / YY) _____ ❑ 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:

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 www.medavie.bluecross.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.

*not applicable in Ontario or Quebec