MEDAVIE BLUE CROSS™

APPLICATION FOR BENEFITS STATEMENT BY EMPLOYEE

PO BOX 668, STATION B MONTREAL, QC H3B 3K3 PHONE : 1-877-849-8509 FAX : 1-844-244-8198 salaire@medavie.croixbleue.ca

Making a false or a misleading statement in an application form is a serious offence. All boxes below must be filled out and must contain truthful information.
You must also complete the questionnaire on training and work experience overleaf.
If the information provided is incomplete, this may delay processing of your claim.

You must notify Medavie Blue Cross of any changes that may affect your eligibility for benefits: improved health, a return to work, participation in a training or rehabilitation programme.

Group/employer name: _____

Name: ❑ Mr ❑ Ms _____ Date of birth: YYYY MM DD
Last name First name Initials

Address: _____ Postal code: _____

_____ Home phone no.: _____

Email: _____ Cellphone: _____

If your condition was caused by an accident, enter the date and a description of the accident: _____

_____

What is your current state of health? _____

What treatment are you currently receiving? _____

What medication are you currently taking? _____

Have you ever suffered from a similar condition? ❑ Yes ❑ No If yes, enter the date and description: _____

_____

Do you currently suffer from other conditions? _____

State the start date of the condition and the reasons why it prevents you from working _____

_____

State the name of the physician who is treating your current condition and the names of all practitioners who have treated you in the last three years (attach a list on a separate piece of paper if there is not enough space).

Physician or hospital (name and place)	Reason	Date of your first visit (YYYY/MM/DD	Date of your last visit (YYYY/MM/DD)

Have you sent a claim to another insurer or received benefits from another source (Workers' Compensation Board, QPP, car insurance, insurance companies, government agencies)?

Name of benefit source	Date of claim (YYYY/MM/DD)	Benefit amount	Frequency of payments	Start of benefits (YYYY/MM/DD)	End of benefits: (YYYY/MM/DD)

All responses and statements entered in the following fields must be complete and truthful; making a misleading or inaccurate statement in an application form is an offence. If the information provided in the form is incomplete, this will delay processing of the claim. You must notify Medavie Blue Cross of any changes that may affect your eligibility for benefits. You must notify us when your medical condition improves, when you return to work or when you participate in a training or rehabilitation program.

- I herewith authorize Medavie Blue Cross to obtain any medical or personal information related to claims submitted by me or on my behalf to any licensed physician, practitioner, hospital, clinic or other medical or paramedical institution, insurance company or other organization, institution or person or to disclose this to them.
- I authorize Medavie Blue Cross to obtain my personal information (not including medical information) from my employer, my benefit plan sponsor or my benefit plan administrator when it is relevant to do so in relation to discussion of rehabilitation or for planning a return to work, or to disclose this information.
- I understand that the personal information provided on this form as well as any other personal information that Medavie Blue Cross or the Blue Cross Life Insurance Company of Canada* holds or will obtain in the future may be collated, used or disclosed in order to administer the provisions set out in my policy or the group policy of which I am an eligible member, and for conducting the business affairs of Medavie Blue Cross or Blue Cross.

Depending on the type of coverage I carry, limited personal information may be collected from a third party and/or disclosed to the latter. These third parties include other Blue Cross companies, healthcare professionals or healthcare providers, life and health insurance providers, government and regulatory authorities, auditors and other third parties when necessary to administer the guarantees set forth in the policy of which I am an eligible member or to the extent required by law.

I understand that my personal information will be kept confidential and secure. I understand that I may withdraw my consent at any time; However, if I do withdraw my consent, Medavie Blue Cross may not provide me with the coverage or benefits claimed.

I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to the disclosure of my personal information.

Except for in cases of verification, the authorizations must remain valid for the duration of my claim or until I withdraw it.

For all employees:
I herewith authorize Medavie Blue Cross and the medical advisor and / or the employer's disability specialist to exchange medical and personal information to facilitate rehabilitation and a return to work.

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

NAME IN BLOCK LETTERS _____

SIGNATURE OF EMPLOYEE _____ DATE _____

A photocopy of this authorization shall be as valid as the original. This consent form complies with federal and provincial privacy laws.
For more information about Medavie Blue Cross's privacy policies, please visit www.medavie.croixbleue.ca or call 1-800-667-4511.

* All life insurance and income replacement benefits are established by Blue Cross Life Insurance Company of Canada.

TRAINING AND WORK EXPERIENCE

Employee's name _____ Policy No. _____

Company name _____ ID No. _____

EDUCATION/TRAINING

a) Formal education (list schools, universities, technical colleges, as well as the highest diplomas and certificates obtained)

_____

_____

_____

_____

_____

b) Skills and vocational training (list in service training and tasks performed, correspondence courses, internships, hobbies and interests, etc.)

_____

_____

_____

_____

_____

WORK EXPERIENCE

List all your previous employers

Name of employer	Date	Job title

_____ _____

Signature of employee Date