APPLICATION FOR BENEFITS EMPLOYEE'S STATEMENT

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MONCTON NB E1C 8L3
TEL: 1-800-667-4511
FAX: 1-800-644-1722

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-800-667-4511
FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-800-355-9133
FAX: 416-626-0400

PO BOX 668 STATION B
MONTREAL QC H3B 3K3
TEL: 1-800-456-6595
FAX: 1-844-244-8198
salaire@medavie.bluecross.ca

It is an offence to make a false or misleading statement in an application for benefits and all the answers and statements in the fields below must be completed and true. Please also complete the Education and Work History questionnaire on reverse. Missing information could result in a delay in the adjudication of your application.

You must notify Medavie Blue Cross of any changes that may affect your eligibility for benefits. This includes an improvement in your medical condition, a return to work or entry into training or rehabilitation programs.

I have read the above and agree. ______________________________

Signature of Employee

Name: ❑ Mr ❑ Mrs ❑ Miss ❑ Ms

____
Last First Initial

Date of Birth ______ | ____ | ____
YYYY MM DD

Address: ______________________________

Postal Code: ______________________________

Telephone: ( ) ______________________________

If your condition is due to an accident, provide the date and details of accident: ______________________________

What is the nature of your current medical condition? ______________________________

What is the current treatment? ______________________________

What medication are you currently taking? ______________________________

Have you ever had a similar condition? ❑ Yes ❑ No If yes, state when and describe: ______________________________

Do you have any other medical conditions at this time? ______________________________

Please give the date and reasons this condition is preventing you from working ______________________________

Provide the name of the physician who is currently providing treatment for this condition and the names of all medical practitioners who have treated you in the last three years. (Please attach a list if insufficient space.)

Physician or Hospital (Name and Location)	Reason	Date of First Visit YYYY/MM/DD	Date of Last Visit YYYY/MM/DD

Have you applied for or are you receiving accident or disability benefits from other sources? (i.e. WCB, CPP, automobile insurance, insurance companies, government agencies.)

Name of Source	Date of Application YYYY/MM/DD	Benefit Amount	Frequency of Payment	Benefit Start Date YYYY/MM/DD	Benefit End Date YYYY/MM/DD

I authorize that my Social Insurance Number may be used by any provider or administrator of my group benefits plan as my personal identification number (Cert. No./ID No.) for claims information, billing records and plan contributions for me and my dependents.

Social Insurance Number: ______________________________

I hereby authorize Medavie Blue Cross to obtain from or release to any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person, any medical information that relates to claims submitted by me or on my behalf.

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, and to manage Medavie 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, 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 Medavie 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.

Signature ______________________________ Date ______________________________

A photocopy of this authorization shall be as valid as the original. 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.

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EDUCATION AND WORK HISTORY

Employee Name ______________________ Group/Policy No. ______________________

Company Name ______________________ Identification No. ______________________

EDUCATION

a) Formal Education (List school, university, technical college, highest grade achieved/credits/diplomas/degrees)

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b) Skills/Training (Please include on-the-job training/duties, correspondence courses, apprenticeships, hobbies and interests, etc.)

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WORK HISTORY

List all types of previous employment

Name of Employer	Date	Job Title

______________________ Signature of Employee

______________________ Date