SASKATCHEWAN BLUE CROSS®

1.800.667.6853 | sk.bluecross.ca

GROUP CRITICAL ILLNESS CLAIM FORM

EMPLOYER STATEMENT

Employee Name | Policy Number | Identification Number

Effective Date of Hire (YYYY/MM/DD) | Does employee have family coverage? | Date Employed (YYYY/MM/DD)

Effective Date of Critical Condition Coverage (YYYY/MM/DD)

Is coverage still in force? ☐ Yes ☐ No

If no, date cancelled. (YYYY/MM/DD) _____

If no, explain the reason(s) the coverage was cancelled.

Is employee actively at work? ☐ Yes ☐ No

If no, what was the last day worked? (YYYY/MM/DD) _____

If no, explain the reason(s) the employee discontinued work.

Does the employee have an active Life Waiver of Premium claim? ☐ Yes ☐ No

If yes, what was the effective date the premiums started to be waived? (YYYY/MM/DD) _____

I hereby declare that the answers to the above questions are accurate and complete.

Employer | Name | Title

Signature | Date (YYYY/MM/DD) | Phone Number | Email

CLAIMANT STATEMENT

Claimant Name | Claimant Street Address/PO Box

City/Town | Province | Postal Code

Telephone Number | Email | Claimant Date of Birth (YYYY/MM/DD)

Name of Beneficiary | Beneficiary Email Address | Beneficiary Phone

If this claim is being submitted for a dependent, please complete the following section.

Last Name of Dependent | First Name

Date of Birth (YYYY/MM/DD) | Relationship to Insured

☐ Check box if address is same as insured

Street Address/PO Box | City/Town | Province

Postal Code | Telephone Number | Email

Diagnosis/Nature of Condition: _____

Date of onset condition (YYYY/MM/DD)

Have you had this condition before? ☐ Yes ☐ No

If yes, when? (YYYY/MM/DD)

COMPLETE FORM ON NEXT PAGE.

Names and contact information of all medical practitioners who treated you for this condition (please attach a list if more space is required).

	Medical Practitioner Name	Address	Telephone Number	Fax Number
Family Doctor				
Specialist				
Specialist				
Specialist				

Name(s) and location of hospital(s) in which you were treated (please attach a list if more space is required).

Name of Hospital City/Province

Have you submitted a Critical Condition claim which has been paid by another insurance company? ☐ Yes ☐ No

If yes, what was the date of claim approval? (YYYY/MM/DD) _____

If yes, please explain the condition:

ACKNOWLEDGMENT & CONSENT

I declare that the answers to the questions on this form are complete and accurate. I understand that the personal information I have provided may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, claims adjudication and payment, administering products and services, audit and investigation.

For the above purposes, I authorize any physician, pharmacy, practitioner or other health care provider, hospital, clinic or other medical facility, insurer, employer (past and present), provincial workers compensation plan, medical or benefit payment plan, government or regulatory authority, or other organization, institute or person that has any records or knowledge of me or my health to give Saskatchewan Blue Cross or Blue Cross Life Insurance Company of Canada full particulars of such information, including any prior medical history relevant to this claim and benefits. I further authorize Saskatchewan Blue Cross and Blue Cross Life Insurance Company of Canada to exchange this information with each other, their reinsurers, investigative agencies or to any third party when required for a purpose stated above. Medical information may also be released to my personal physician or other medical practitioner.

I agree and am aware Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may engage a collection agency to collect any overpayment that occurs during the course of my life and/or disability claim.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, 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 the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853. A photocopy of this authorization shall be as valid as the original.

Claimant Printed Name Claimant Signature

Date