MEDAVIE BLUE CROSS™

TERMINAL ILLNESS CLAIM FORM

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

230 BROWNLOW AVE, DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

PO BOX 2000, STN A
ETOBICOKE ON M9C 5P1
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

Please also have the Group Administrator complete the Employer Statement, FORM-1143, and submit to Medavie Blue Cross.

CLAIMANT STATEMENT

Employee Name: _____ Date of birth (DD/MM/YYYY): _____

Policy Number: _____ Email Address: _____

Address: _____

City: _____ Postal Code: _____ Telephone Number: _____

Amount Requested: _____

IRREVOCABLE BENEFICIARY AGREEMENT

If your beneficiary is irrevocable please have the beneficiary complete this section.

I _____, having been named as an irrevocable beneficiary of the named employee within the policy mentioned above, hereby release all of my rights, titles or interests in the portion of the life insurance proceeds that is payable to the insured under the Terminal Illness benefit contract provision of this policy in the event that this benefit is claimed and deemed to be payable.

Signature: _____ Date: _____

FINANCIAL INSTITUTION INFORMATION

ATTACH A VOID CHEQUE OR DIRECT DEPOSIT INFORMATION FROM YOUR ONLINE BANKING.

CLAIMANT AUTHORIZATION

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.
Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

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.

MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN'S STATEMENT
TERMINAL ILLNESS CLAIM FORM

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

230 BROWNLOW AVE, DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

PO BOX 2000, STN A
ETOBICOKE ON M9C 5P1
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-877-849-8509
FAX: 1-800-644-1722
absence@medavie.ca

PART 1: PATIENT AUTHORIZATION

Patient Name: _____ Date of birth (DD/MM/YYYY): _____

I hereby authorize the release to my insurer of any information in respect of this application.

Signature: _____ Date (DD/MM/YYYY): _____

PART 2: ATTENDING PHYSICIAN'S STATEMENT

Diagnosis:

A) Primary:

B) Secondary:

C) Additional Conditions or Complications:

Date Symptoms Appeared (DD/MM/YYYY): _____

In your opinion, what is your patient's life expectancy? (mandatory)

Please provide any information that would be relevant for this application:

Physician's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Fax Number: _____

Signature: _____ Date (DD/MM/YYYY): _____