MEDAVIE BLUE CROSS™

APPLICATION FOR BENEFITS EMPLOYEE'S STATEMENT

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 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-877-849-8509
FAX: 1-800-644-1722
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1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-877-849-8509
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Applications for disability benefits can also be submitted securely by logging into our Member Services Site at www.medaviebc.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 accompanying Education and Work History questionnaire. 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.

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

Name: _____
Last First Initial

Date of Birth (DD/MM/YYYY): _____

Address: _____ Postal Code: _____

Email Address: _____ 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 DD/MM/YYYY	Date of Last Visit DD/MM/YYYY

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

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FINANCIAL INSTITUTION INFORMATION

Direct deposit information is not required if salary continuation benefits are paid by your Employer.

ATTACH SAMPLE CHEQUE MARKED "VOID" HERE OR IF CHEQUE IS NOT AVAILABLE, COMPLETE INFORMATION BELOW:

Name of Bank: _____ Bank Address: _____

Financial Institution Number: _____ Branch Number: _____ Account Number: _____

I request my benefits be paid through electronic funds transfer (direct deposit) into this account. I may cancel this authorization at any time by giving written notice to Blue Cross.

Signature: _____ Date: _____
DD/MM/YYYY

I authorize that my Social Insurance Number may be used by any provider or administrator of my group benefits plan for income tax purposes. I understand if my benefit plan is non-taxable I am not required to provide my Social Insurance Number.

Social Insurance Number: _____

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.

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

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

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EDUCATION AND WORK HISTORY

This information is not required if you are applying for Short Term Disability or Salary Continuation Benefits.

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Employee Name: _____ Group/Policy No.: _____

Company Name: _____ Identification No.: _____

EDUCATION

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

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

WORK HISTORY

List all types of previous employment

Name of Employer	Date	Job Title

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