644 Main St, PO Box 220, Moncton NB E1C 8L3
Fax: 506-869-9654 1-800-387-4343
groupmedicalunderwriting@medavie.bluecross.ca

100-1981 McGill College Avenue, Montreal QC H3A 3A7
Fax: 514-286-8444 1-888-337-5125
groupmedicalunderwriting@medavie.bluecross.ca

SPECIAL DEPENDENT QUESTIONNAIRE

Attention: Medical Underwriting Department

This questionnaire must be completed in part by your dependent's personal physician to assess his/her eligibility to be registered as a special dependent. Any associated costs will be the responsibility of the applicant. Once completed, please send the form by email to groupmedicalunderwriting@medavie.bluecross.ca.

Applicant Name: _____ Telephone Number: _____

Dependent Name: _____ Identification Number: _____

Date of Birth : _____
YYYY/MM/DD

SUBSCRIBER QUESTIONNAIRE

1. Is the dependent totally incapable of employment or attending school due to mental and/or physical disability?
   ○ Yes ○ No
   If yes, please indicate the date the dependent became totally disabled: _____
2. Has there been an appointment granted for Power of Attorney for dependent for whom you are applying?
   ○ Yes ○ No
   If yes, please indicate the name of individual with Power of Attorney: _____
3. What assistance is required for the dependent to carry out the following activities of daily living: eating, dressing, bathing, ambulating, and toileting: _____
4. Where does the dependent reside?
   ○ Family Residence ○ Special Care Facility ○ Other (please specify): _____

PHYSICIAN'S QUESTIONNAIRE

1. Please state the diagnosis, the date diagnosed and details of treatment, including prescribed medication required.

2. Please describe any limitations of your patient's physical and/or mental capabilities. Are these limitations permanent or temporary? If temporary, is there an expected recovery date?

Physician Identification

Name: _____
(PLEASE PRINT)

Physician Signature : _____ Date : _____
YYYY/MM/DD

I hereby authorize the above physician to complete this form and provide any records or knowledge of me or my health, to Blue Cross Life Insurance Company of Canada and/or Medavie Blue Cross.

Subscriber Signature (or individual with Power of Attorney): _____

Date : _____
YYYY/MM/DD

Dependent Signature (if 18 years of age or over): _____

FORM-226E 07/24