MEDAVIE BLUE CROSS™

SPECIAL DEPENDENT QUESTIONNAIRE

PO BOX 220 MONCTON NB E1C 8L3 TEL: 1-800-667-4511 FAX: 506-869-9654 E-MAIL: groupmedicalunderwriting@medavie.bluecross.ca

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 employee. When completed, please mail or fax to Medavie Blue Cross.

Employee Name: ______________________________ Policy Number: ______________________

Dependent Name: ______________________________ Identification number: ______________________

Date of Birth: ______________________________

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 the 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: ______________________

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.

Employee Signature: ______________________________ Date: ______________________
(or individual with Power of Attorney)

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

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