SASKATCHEWAN BLUE CROSS®

Print | Clear Form

APPLICATION FOR CRITICAL CONDITIONS BENEFIT

PO Box 4030 Saskatoon SK S7K 3T2
306.244.1192 Toll-free in Saskatchewan 1.800.667.6853
Fax 306.652.5751 sk.bluecross.ca

PART I: EMPLOYER STATEMENT

Employee Name	Policy No.	Identification No.

Effective date of employee's coverage	Employee Class	Does employee have family coverage?	Date Employed
_____ I _____ I _____ DD MM YYYY		◯ Yes ◯ No	_____ I _____ I _____ DD MM YYYY

Effective date of employee's coverage for Critical Conditions	Is employee actively at work? ◯ Yes ◯ No If no, what is date last worked? _____ I _____ I _____ DD MM YYYY If no, explain the reason(s) the employee discontinued work.
Is coverage still in force? ◯ Yes ◯ No If no, date cancelled _____ I _____ I _____ DD MM YYYY If no, explain the reason(s) the coverage was cancelled.	

Employer _____ Title _____

Date _____ Signature _____ Email _____

PART II: CLAIMANT STATEMENT

Claimant Name	Telephone Number _____ Email _____
Claimant Address _____ PO Box/Street Address _____ City or Town Province Postal Code	Claimant Date of Birth _____ I _____ I _____ DD MM YYYY

Date of onset of condition	Have you had this condition before?	Describe the condition.
_____ I _____ I _____ DD MM YYYY	◯ Yes When _____ I _____ I _____ DD MM YYYY ◯ No	

Names of all medical practitioners who treated you for this condition.	Name(s) of hospital(s) in which you were treated.

I, the undersigned, declare that my answers are complete and accurate and form part of an application for benefits with Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada®. I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, the Medical Information Bureau, government and regulatory authorities, any Saskatchewan Health Agency including the Saskatchewan Prescription Drug Plan, the policy holder or certificate holder of any policy under which I am a participant, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; 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-USEBLUE®.

Dated at _____ this _____ day of _____ 20 _____

_____ _____
Claimant Signature (Employee if Claimant is under legal age) Address Postal Code

_____ _____
Witness Address Postal Code

603-038 (08/15)