

**EMPLOYEE STATEMENT**

Employee Name \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

Company Name \_\_\_\_\_ Identification Number \_\_\_\_\_

**EDUCATION**

Please complete Education section or attach a copy of your most recent résumé.

1. Formal Education (list school, university, technical college with credits/diplomas/degrees received or highest grade achieved)

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

**WORK HISTORY**

List all types of previous employment.

Name of Employer	Date	Job Title

I declare that the answers to the questions on this form are complete and accurate. I understand that the personal information I have provided may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation.

For the above purposes, I authorize any physician, pharmacy, practitioner or other health care provider, hospital, clinic or other medical facility, insurer, employer (past and present), provincial workers compensation plan, medical or benefit payment plan, government or regulatory authority, or other organization, institute or person that has any records or knowledge of me or my health to give Saskatchewan Blue Cross or Blue Cross Life Insurance Company of Canada full particulars of such information, including any prior medical history relevant to this claim and benefits. I further authorize Saskatchewan Blue Cross and Blue Cross Life Insurance Company of Canada to exchange this information with each other, their reinsurers, investigative agencies or to any third party when required for a purpose stated above. Medical information may also be released to my personal physician or other medical practitioner.

I agree and am aware Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may engage a collection agency to collect any overpayment that occurs during the course of my life and/or disability claim.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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](http://www.sk.bluecross.ca) or call 1.800.667.6853. A photocopy of this authorization shall be as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

