SASKATCHEWAN BLUE CROSS®

1.800.USE.BLUE | 516 - 2nd Avenue N, PO Box 4030
Saskatoon, Saskatchewan S7K 3T2

PLAN MEMBER CONFIRMATION OF INJURY/ILLNESS FORM

PLEASE NOTE:
In recognition of the increasing pressure on our medical clinics and hospitals due to the COVID-19 pandemic, we may not, at the outset, require an Attending Physician's Statement as part of your new or ongoing disability claim. Please complete this form in the event you were unsuccessful in having your treatment provider complete one, or if you were unable to consult with your treatment provider. This is a time limited exception as we move through the current situation. Please note however, we reserve the right to request further medical information depending on the information provided below.

PLEASE SEND COMPLETED FORM TO:
Saskatchewan Blue Cross
PO Box 4030
Saskatoon, SK S7K 3T2

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms, any test results, and any medical treatment you may have received for your condition.

Please ensure all questions are answered. Additional statements may be submitted if there is insufficient space on this form. Refer to your booklet for information about your plan.

1 Plan Member Information

You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.

Plan sponsor name _____

Plan contract number _____ Division _____ Certificate number _____

Full name (first, middle initial, last) _____

SIN (if benefit is taxable) _____ Date of birth (dd/mmm/yyyy) _____ Sex _____

Height _____ Weight _____ Number of dependents and ages _____ Language preference: ◯ English ◯ French

Street address (number, street, apt.) _____

City _____ Province _____ Postal code _____

Primary phone number _____ Alternate phone number _____

Work phone number _____ Ext. _____

Email address _____

◯ I consent to receiving email messages relating to this claim.

◯ I **DO NOT** consent to receiving email messages relating to this claim.

2 Direct Deposit Authorization

If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.

☐ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement**

☐ **If depositing into a chequing account, please sign the authorization, and attach a copy (or a photo) of a void cheque**

Name of financial institution _____

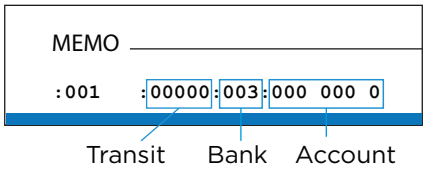
Address of financial institution (number, street, suite) _____

City _____ Province _____ Postal code _____

Type of account: ☐ Chequing ☐ Savings

Branch or transit number (5 digits) _____ Institution number (3 digits) _____

Bank account number (maximum 12 digits) _____



I hereby authorize Saskatchewan Blue Cross to deposit funds to the account identified on this form. I also authorize Saskatchewan Blue Cross to withdraw funds required to correct amounts that may have been deposited in error, on the understanding that I will be notified of the adjustment prior to any with-drawal. This authorization may be changed or cancelled at any time by submitting written notice to Saskatchewan Blue Cross.

Plan member signature _____ Date (dd/mmm/yyyy) _____

Plan member name (please print) _____

3 Other Income

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.

Source	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Date benefit commenced? (dd/mmm/yyyy)	Amount ($)	Please describe or provide claim number, contact name and telephone number
Canada/Quebec Pension Plan							
◯ Disability	☐	☐	☐	☐			
◯ Retirement							
Worker's compensation*	☐	☐	☐	☐			
Employment insurance	☐	☐	☐	☐			
Auto insurance	☐	☐	☐	☐			
Other insurance	☐	☐	☐	☐			
Income from any other source	☐	☐	☐	☐			

*Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

4 About your work

Occupation _____

Original date of hire (dd/mm/yyyy) _____

What was the last date at work? (dd/mmm/yyyy)

Was this a full day/shift? ◯ Yes ◯ No, how many hours did you work on your last day?

Date first absent from work due to this illness/injury (dd/mm/yyyy) _____

Have you performed any other paid or volunteer work since that date? Yes ☐ No

If yes, please describe:

Dates (dd/mmm/yyyy)

_____ From _____ To _____

_____ _____ To _____

Employment status

Is your employer currently operating fully, as usual? ◯ Yes ◯ No

If no, I am currently:

◯ Working full time from home

◯ Working reduced hours

◯ Laid off temporarily as of (dd/mm/yyyy) _____

◯ Laid off permanently as of (dd/mm/yyyy) _____

Have you applied for any form of Employment Insurance Benefits? ◯ Yes ◯ No

If yes, on what date did you apply (dd/mm/yyyy) _____

Type of benefit you applied for _____

5 About Your Absence

VERY IMPORTANT: the details in this form provide the information we need to assess your claim. It's very important to provide accurate information about you and your condition. Please complete the information below carefully and be sure to sign section 7 - **Agreement, authorization and acknowledgement** at the bottom of this form.

Injury details -

Is your injury/illness work related? ☐ Yes ☐ No

If *no*, was the reason you stopped working due to: Illness ☐ Injury away from work ☐ Motor vehicle accident (Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

Is there any legal action? ☐ Yes ☐ No If *yes*, please provide the lawyer's contact information.

Lawyer's name _____ Phone number _____ Ext. _____

Lawyer's address (number, street, suite) _____

City _____ Province _____ Postal code _____

Illness details -

Is claim related to symptoms or confirmed case of COVID-19? ○ **Yes** ○ **No**

Primary condition or diagnosis if know

Secondary condition or diagnosis if known

If childbirth provide expected or actual delivery date (dd/mmm/yyyy)

Vaginal ☐ C-Section ☐

Please describe your symptoms and their frequency.

Explain how these symptoms prevent you from performing your work duties.

Have you ever had the same or similar illness or injury? ○ Yes ○ No

Did it result in an absence from work? ○ Yes ○ No If *yes*, please describe, include dates and treatment provided.

Hospitalization -

Were you: ○ Hospitalized ○ or had day surgery

Date admitted (dd/mmm/yyyy):

Date discharged (dd/mmm/yyyy):

Name of institution:

If surgery was performed provide date and description of surgery (dd/mm/yyyy)

Description:

Treatment details -

Please describe the treatement you are receiving (e.g. medication and dosage, physiotherapy, psychotherapy, etc):

Date first treated for this absence? (dd/mmm/yyyy)

Who did you first see (doctor, walk-in clinic, Assessment Center, chiropractor, Nurse, etc)? Provide their name and location:

Treatment details (continued) -

How are you accessing treatment right now?

○ In clinic or in hospital ○ On the phone ○ Virtually via computer/electronic device ○ Other: _____

How often are you speaking with your treatment provider? ○ Daily ○ Weekly ○ Monthly ○ Other, please describe: _____

Date of last treatment (dd/mm/yyy) _____ Date of next treatment (dd/mm/yyyy) _____

Healthcare provider information - Please provide your primary healthcare provider's contact details (e.g. family physician, nurse practitioner, specialist, physiotherapist, psychologist, etc.). Please attach a seperate page and list any additional healthcare providers you may be seeing.

Name _____ Specialty _____

Address of health care provider (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number _____ Fax number _____

Test results -

If COVID-19 related, was test performed? ○ **Yes** ○ **No**

If yes, it was : ○ **Positive** ○ **Negative** ○ **Pending, date expected:** _____

Are any specialist consultations or tests under way, or planned? ○ Yes ○ No

If yes, Please describe with who, type of test, and the dates:

If available, provide copies of any test results, e-medical records, hospital visit receipts or other records that help explain your illness and work absence.

Prognosis -

Date you expect to return to work (dd/mmm/yyyy)

If no expected return to work date, please explain:

Other details - explain your absence from work

Is there anything else about your condition you feel we should know that would help us understand why you're unable to work at this time? Please explain.

6 Be sure to notify us promptly in the following cases

I acknowledge I must notify Saskatchewan Blue Cross immediately if:

a) my medical condition improves, even though I have not yet returned to work
b) I start work either as an employee or a self-employed person
c) I apply for benefits under any workers' compensation law or plan as defined in section 3
d) I apply for benefits under Canada/Quebec Pension Plan
e) I receive any benefits or income from any other source
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disability
h) I am leaving the country or traveling
i) I am or will be returning to school

Plan member signature _____

Date (dd/mmm/yyyy) _____

7 Agreement, authorization and acknowledgement

Please remember to sign this authorization page and send it to us along with your completed Plan Member Statement Form.

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its authorized agents for the purposes of determining eligibility for coverage, underwriting, claims adjudication and payment, administering products and services, audit and investigation. This personal information and personal health information includes, but it not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results.

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 or call 1-800-USEBLUE®.

Plan member signature _____ Date (dd/mmm/yyyy) _____

Plan member name (please print) _____

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Saskatchewan Blue Cross and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.