SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

APPLICATION FOR TERMINAL ILLNESS BENEFIT

EMPLOYER'S STATEMENT

Employee's Name | Policy Number | Identification Number

Effective Date of Life Coverage (YYYY-MM-DD) | Employee Class | Date Employed (YYYY-MM-DD) | Annual Salary

Is employee actively at work? ☐ Yes ☐ No *If* **no,** *provide date last worked* (YYYY-MM-DD): _____

If **no,** *please explain the reason this employee discontinued work:*

Has premium been paid to date? ☐ Yes ☐ No
If **no,** *please provide reason why:*

I hereby declare that the answers to the above questions are accurate and complete.

Employer | Signature

Date (YYYY-MM-DD) | Title

CLAIMANT'S STATEMENT

Claimant's Name | Date of Birth (YYYY-MM-DD)

Address | City/Town | Postal Code | Telephone Number

I, _____, wish to apply for the Terminal Illness Benefit under my group plan.

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, health practitioner or other health care provider, hospital, clinic or other medical or medically related 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 disclose 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 Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.
A photocopy of this authorization shall be as valid as the original.

Claimant Printed Name | Witness Printed Name

Claimant Signature | Witness Signature

Claimant Address | Witness Address

If you have an irrevocable beneficiary designation, please have your beneficiary sign and date the information below.

I understand that the Claimant previously designated me as the Irrevocable beneficiary under their Policy, and I consent to the Claimant receiving the Terminal Illness Benefit and understand that upon death, any payable amounts will be reduced by the amount that is received by the Claimant for the Terminal Illness Benefit.

Irrevocable Beneficiary's Printed Name | Irrevocable Beneficiary's Signature

Irrevocable Beneficiary's Address

TURN OVER TO COMPLETE PHYSICIAN'S STATEMENT.

APPLICATION FOR TERMINAL ILLNESS BENEFIT

PATIENT AUTHORIZATION

Patient's Name | Date of Birth (YYYY-MM-DD)

I hereby authorize the release to my insurer of any medical information in respect of this application.

Patient's Signature | Date (YYYY-MM-DD)

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis

A) Primary:

B) Secondary:

Date Symptoms Appeared (YYYY-MM-DD): _____

Mandatory: In your opinion, what is your patient's life expectancy?

Please provide copies of all relevant test results (including all lab work, investigative tests, pathology reports, hospital records, etc.) or any other pertinent clinical findings.

Is there any other information you wish to provide to assist us in the review of your patient's claim?

NOTICE TO PHYSICIAN

The information in this statement will be kept in a life, health or disability benefit file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, you consent to such unedited release of any information contained herein.

Physician's Name

Address | City/Town | Province

Postal Code | Telephone Number | Fax Number

Physician's Signature | Date (YYYY-MM-DD)