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

APPLICATION FOR CRITICAL ILLNESS BENEFIT

CLAIMANT STATEMENT

Claimant Full Name		Policy No.	
Street Address/PO Box	City/Town	Province	Postal Code
Telephone No.	Email Address	Claimant Date of Birth (YYYY-MM-DD)	
Beneficiary Name	Beneficiary Email Address	Beneficiary Telephone No.	

If this claim is being submitted for a Dependent, also complete this section:

Dependent First Name	Dependent Last Name
Dependent Date of Birth (YYYY-MM-DD)	Relationship to Insured

☐ **Check box if Dependent address is same as Insured**

Street Address/PO Box	City/Town	Province	Postal Code
Telephone No.	Email Address		

Date of onset condition (YYYY-MM-DD): _____ **Have you had this condition before?** ☐ Yes ☐ No

If **yes,** *when?* (YYYY-MM-DD): _____

Diagnosis/Nature of Condition:

Names and contact information of all medical practitioners who treated you for this condition (please attach a list if more space is required):

	Medical Practitioner Name	Address	Telephone No.	Fax No.
Family Doctor				
Specialist				
Specialist				
Specialist				

Name(s) and location of hospital(s) in which you were treated (please attach a list if more space is required):

Name of Hospital	City/Province

COMPLETE FORM ON NEXT PAGE.

Have you submitted a Critical Condition claim which has been paid by another insurance company? ☐ Yes ☐ No

If **yes,** *what was the date of claim approval?* (YYYY-MM-DD): _____

If **yes,** *please explain the condition:*

ACKNOWLEDGMENT & CONSENT

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's Name (Print)	Claimant's Signature	Date (YYYY-MM-DD)