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

GROUP ACCIDENTAL DISMEMBERMENT CLAIM

INSTRUCTIONS:

- Complete this side of the form and arrange for the doctor to complete the reverse side
- Mail the completed form and applicable attachments to Saskatchewan Blue Cross
- **The patient is responsible for securing this form and for charges made for its completion.**

EMPLOYER STATEMENT

Employee's Name	Policy No.	Identification No.
Effective Date of Hire	Employee's Last Day at Work on a FT basis	Effective Date of Dismemberment Coverage

Regular gross earnings:

- ☐ Monthly $_____
- ☐ Yearly $_____
- ☐ Commission-Based — *Attach T4 from previous two years*

Reason for leaving work:

- ☐ Dismissed
- ☐ Temporary Layoff
- ☐ Layoff
- ☐ Retired
- ☐ Disability
- ☐ Quit
- ☐ Leave of Absence
- ☐ Other — *Specify:* _____

Is this claim due to an occupational injury? ☐ Yes ☐ No

Do you know of any reason why this claim should not be paid? ☐ Yes ☐ No *If* **yes,** *give reason:* _____

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

Administrator's Name	Title	Date (YYYY-MM-DD)
Signature	Phone Number	Email

CLAIMANT'S STATEMENT

Claimant's Name	Address	Date of Birth (YYYY-MM-DD) ☐ AM ☐ PM

Phone Number	Email	Date of Accident	Time (HH:MM)

Details of Accident (include how and where it happened, resulting injuries):
If applicable, please enclose a copy of the Police Record and Toxicology Analysis.

I am claiming Dismemberment Benefits due to loss of:

If applicable, please enclose a copy of the Police Record and Toxicology Analysis.

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)

COMPLETE PHYSICIAN'S STATEMENT ON NEXT PAGE.

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GROUP ACCIDENTAL DISMEMBERMENT CLAIM

PHYSICIAN'S STATEMENT (THIS SECTION TO BE COMPLETED BY PHYSICIAN.)

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

Date of Accident (YYYY-MM-DD) | Nature of Accident

Was the injury self-inflicted? ☐ Yes ☐ No
Explain:

Did the accident occur in the course of the patient's occupation or employment? ☐ Yes ☐ No

Did the loss occur from bodily injury caused solely by external, violent and accidental means? ☐ Yes ☐ No
If **no,** *please give details of contributory causes.*

Date of first treatment following accident (YYYY-MM-DD):

Are you aware of any other physician(s) who treated this patient due to this accident? ☐ Yes ☐ No
If **yes,** *please give name(s) and address(es).*

Please enclose copies of all relevant test results (including lab work), hospital records and consultation reports from the date of the accident to present date.

DISMEMBERMENT AND LOSS OF USE

a) If accident resulted in the dismemberment or loss of use of a body part, include the part(s) lost, level and date of amputation, if applicable.
Indicated on the chart outlined below:

Did the accident result in:		**Loss of Use**	**Amputation (If applicable)**	**Level of Amputation**	**Date of Loss (YYYY-MM-DD)**
Hand	☐ Left ☐ Right ☐ Both	☐	☐		
Foot	☐ Left ☐ Right ☐ Both	☐	☐		
Arm	☐ Left ☐ Right ☐ Both	☐	☐		
Leg	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of thumb and fingers (at or above the first interphalangeal joint)					
Thumb #1	☐ Left ☐ Right ☐ Both	☐	☐		
Index finger #2	☐ Left ☐ Right ☐ Both	☐	☐		
#3	☐ Left ☐ Right ☐ Both	☐	☐		
#4	☐ Left ☐ Right ☐ Both	☐	☐		
Little finger #5	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of toes (at or above the first interphalangeal joint)					
Big toe #1	☐ Left ☐ Right ☐ Both	☐	☐		
#2	☐ Left ☐ Right ☐ Both	☐	☐		
#3	☐ Left ☐ Right ☐ Both	☐	☐		
#4	☐ Left ☐ Right ☐ Both	☐	☐		
Little toe #5	☐ Left ☐ Right ☐ Both	☐	☐		
Other					
Loss of speech	☐ Yes ☐ No	☐	☐		
Loss of hearing	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of sight (20/200)	☐ Left ☐ Right ☐ Both	☐	☐		

b) Is the patient:
1) Quadriplegic ☐ Yes ☐ No
2) Paraplegic ☐ Yes ☐ No
3) Hemiplegic ☐ Yes ☐ No

Is the loss total and irrecoverable? ☐ Yes ☐ No

Remarks:

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 (Print) | Specialty | Address

Telephone No. | Fax No. | Signature | Date (YYYY-MM-DD)