APPLICATION FOR
CRITICAL CONDITION BENEFIT

EMPLOYER'S STATEMENT

Employee's Name	Policy No.	Identification No.

Effective date of employee's coverage with Blue Cross	Employee Class	Does employee have family coverage?	Date Employed
________ / ________ / ________ DD MM YYYY		❑ Yes ❑ No	_______ / _______ / _______ DD MM YYYY

Effective date of employee's coverage for Critical Condition ________ / ________ / ________ DD MM YYYY	Is employee actively at work? ❑ Yes ❑ No If no, what is date last worked? ________ / ________ / ________ DD MM YYYY
Is coverage still in force? ❑ Yes ❑ No If no, date cancelled ________ / ________ / ________ DD MM YYYY Reason cancelled:	If no, please explain the reason this employee discontinued work.

Employer ______________________________ Signature ______________________________

Date ______________________________ Title ______________________________

CLAIMANT'S STATEMENT

Claimant's Name	Telephone Number ( ) ______________________
Claimant's Address ______________________ (P.O. Box No/Street Address) ______________ ______________ ______________ (City or Town) (Province) (Postal Code)	Claimant's Date of Birth ________ / ________ / ________ DD MM YYYY

Date of onset of condition	Have you had this condition before?	Describe the condition
_________ / _________ / _________ DD MM YYYY	❑ Yes When _______ /_______ / _______ DD MM YYYY ❑ No	

Please give name(s) of all medical practitioners who treated you for your condition:	Name(s) of hospital(s) in which you were treated:

I hereby certify that the above information is correct to the best of my knowledge and belief.

I understand that the personal information provided herein, as well as any other personal information currently held, or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy, to develop and recommend suitable products and services to me, and to manage the Company’s business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, any Saskatchewan Health Agency including the Saskatchewan Prescription Drug Plan, the policy holder or certificate holder of any policy under which I am a participant, and other third parties when required to administer the benefits outlined in my policy.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the 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 Saskatchewan Blue Cross’ privacy policies, I can contact Saskatchewan Blue Cross at www.sk.bluecross.ca or 1-800-USE-BLUE should I have questions as to the collection, use of or disclosure of my personal information.

I authorize Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada to collect, use and disclose the personal information as described above.

Dated at ______________________ this __________ day of ______________________ 20 _______

______________________________ ______________________________

Signature of Claimant or Employee if Claimant is under legal age — Address — Postal Code

______________________________ ______________________________

Signature of Witness — Address — Postal Code

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