ALBERTA BLUE CROSS®

APPLICATION FOR BENEFITS
EMPLOYEE STATEMENT

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 587-756-8631 or 1-800-763-6206
Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

To be completed by the plan member. Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.

Name of your employer	☐ Short-term disability (weekly indemnity)
Your position/job title (as of the last day that you worked)	☐ Long-term disability ☐ Waiver of premium

Employee (plan member) information

Last name		First name		Middle initial
Group/policy number	Section	ID number	Birth date (YYYY-MM-DD)	Gender ☐ M ☐ F
Mailing address		City/town	Province	Postal code
Home phone number	Work phone number	Cell phone number	Email address	

Disability information

When was the last day you worked? (YYYY-MM-DD)	When was the first day that you missed a scheduled day of work? (YYYY-MM-DD)

What is the reason that you are off work, such as the condition or diagnosis?

What is the cause of your condition? ☐ illness ☐ accident ☐ occupational illness* ☐ workplace accident* ☐ vehicle accident*

** If your work absence is caused by occupational illness, workplace accident or vehicle accident, please attach the claim made to your provincial workers' compensation board or other relevant organization. A copy of all correspondence with these organizations will also be required.*

When did your symptoms first appear? (YYYY-MM-DD)	When was the first day that you saw a physician after you stopped working? (YYYY-MM-DD)

Were you hospitalized for this condition? ☐ Yes ☐ No	If yes, where?	Duration of hospitalization (YYYY-MM-DD) to (YYYY-MM-DD)

How does your condition impact your ability to perform your work duties? (describe the reason this condition is preventing you from working)

Have you had a similar condition? ☐ Yes ☐ No If yes, state when and describe (YYYY-MM-DD)			
Did it result in an absence from work? ☐ Yes ☐ No	If yes, state when (YYYY-MM-DD)	Has your physician told you when you can return to work? ☐ Yes ☐ No	Date of return to work (YYYY-MM-DD)

For an accident, provide the following information

Date (YYYY-MM-DD) Time	Location	Name of witness	Causes/circumstances

Police report ☐ Yes ☐ No If yes, attach a copy

Medical information

After you stopped working, provide information of any physician, medical practitioner or care provider that you have consulted *(attach a separate page if there is insufficient space)*

Provider	First date (YYYY-MM-DD)	Last date (YYYY-MM-DD)	Next date (YYYY-MM-DD)

Medical information (*continued)*

Describe your current treatment plan

Did you undergo or are you waiting for tests, treatments, consultations or surgery? ☐ Yes ☐ No If yes, please specify

List any current medication (prescription or non-prescription) that you are taking at this time *(attach a separate list if there is insufficient space)*

Name of medication	Start date (YYYY-MM-DD)	Last date of change (YYYY-MM-DD)	Current dosage	Frequency

Medical history

List any other health related condition that you may have at this time

Indicate all physicians or medical practitioners consulted, reason for consultation and treatment (in the past three years). *(attach at list if there is insufficient space)*

Name of Physician	Specialty	Address/phone number	Reason for consultation	Treatment/medication

Other sources of income *(since the last day worked)*

Have you received any sources of income since being continuously off work? ☐ Yes ☐ No

☐ Salary continuation (YYYY–MM–DD) to (YYYY–MM–DD)

☐ Paid sick leave (YYYY–MM–DD) to (YYYY–MM–DD)

☐ Paid vacation (YYYY–MM–DD) to (YYYY–MM–DD)

☐ Other _____ (YYYY–MM–DD) to (YYYY–MM–DD)

Additional information

Provide any additional information which may be of value in consideration of this application for benefits.

Employee declaration

I understand that Alberta Blue Cross requires all documentation before my application will be adjudicated. An application includes the Employee Statement (including authorization and consent), the Attending Physician's Statement (**including supporting medical information**) and the Employer's Statement (including job description of job duties).

I understand it is my responsibility to submit a complete application, and that I am responsible for any fees related to the completion of my application. Missing information could result in delayed adjudication or denial of my claim.

I agree to notify Alberta Blue Cross, Life & Disability Services, of any changes that may affect my eligibility for benefits. This includes an improvement in my medical condition, a return work, or entry into treatment or rehabilitation programs.

Plan member name (please print)	Signature of plan member	Date (YYYY–MM–DD)

ACKNOWLEDGEMENT AND CONSENT

I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its agents to collect, use, maintain and disclose personal information for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claim management. I acknowledge and agree that my personal information may only be collected from and/or released to a third party (health care professional/practitioner/insurer or reinsurer/agent of record/my employer) only when needed for a purpose stated above. Medical and health information excludes genetic test results.

I understand that I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.

I understand why I have been asked to disclose this information and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

I agree that this consent shall be effective on the date of this application and shall be valid for the duration of the time coverage is in force.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please visit our web site at ab.bluecross.ca or email our privacy compliance officer at privacy@ab.bluecross.ca.

Plan member name (please print)	Signature of plan member	Date (YYYY-MM-DD)

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.