ALBERTA BLUE CROSS®

ATTENDING PHYSICIAN STATEMENT
CRITICAL ILLNESS BENEFIT

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

Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.
It is the responsibility of the plan member to submit the Employee Statement and Attending Physician Statement.
The plan member is responsible for submitting this completed form and accepting any charges for its completion.

1. This section to be completed by employee (plan member)

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Gender ☐ M ☐ F

Address	City/town	Province	Postal code

Home phone	Cell phone	Email	Height	Weight

Employer's name	Group/policy number	Section	ID number

Last name of claimant (if not plan member)	First name of claimant (if not plan member)	Relationship to plan member	Birth date of claimant (YYYY-MM-DD)

I hereby authorize the release of health information in my file by the health-care provider listed on this form to Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its authorized agents for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claims management. This health information includes, but is not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results. I confirm that I am authorized by my spouse and dependants to receive and disclose information about them that is used solely for these purposes.

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I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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 noted below and shall be valid for the duration of the time my benefit 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 refer to **ab.bluecross.ca** or email our privacy compliance officer at privacy@ab.bluecross.ca.

Signature of employee (plan member)	Date of consent (YYYY-MM-DD)

2. Attending physician statement TO BE COMPLETED BY THE DOCTOR

I am the ☐ attending physician ☐ consulting specialist ☐ other (please specify) ____________________

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary diagnosis

Secondary diagnosis

Additional illness or complications

Date symptoms first appeared (YYYY-MM-DD)	Has patient ever had same or similar illness? ☐ Yes ☐ No	If yes, give dates and details

Date patient first received medical treatment, diagnostic measures, medication or consultation for this illness (YYYY-MM-DD)	Date of first treatment for this illness, if different from above (YYYY-MM-DD)	Date of last treatment for this illness (YYYY-MM-DD)

2. Hospitalization

Was the patient in hospital? ☐ Yes ☐ No	Name and address of hospital		
Dates of hospital treatment (YYYY-MM-DD)	Outpatient	OR inpatient admission	Discharge
Surgical treatment, if any			
Date (YYYY-MM-DD)	Details		
1.			
2.			

3. Other information

Are you aware of any other physicians who treated this patient due to this present illness? ☐ Yes ☐ No

If yes, please give names and addresses

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

Please summarize your patient's medical history (attach copies of tests administered including the results of any relevant clinical findings)

List all objective findings	List all subjective findings

Please indicate how activities of daily living are affected by this illness

Eating	
Dressing	
Bathing	
Ambulation	
Toileting	

Cardiac functional capacity (if applicable as defined by the Canadian Cardiovascular Society).

☐ Class I–no limitations ☐ Class II–slight limitations

☐ Class III–marked limitations ☐ Class IV–complete limitations

Please forward results of stress tests, angiograms, etc.

Please outline your prognosis for this patient (refer to the list of critical illnesses and conditions)

3. Notice to physician

The information in this statement will be kept in a life, health or disability benefits file with the insurer 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 I consent to such unedited release of any information contained herein.

Name of physician (please print)	Physician's specialty			Physician's stamp
Address		Province	Postal code	
Phone	Fax			
Signature		Date signed (YYYY-MM-DD)		

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

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