ALBERTA BLUE CROSS®

APPLICATION FOR 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.

1. To be completed by employer

Last name of employee	First name of employee	Position/job title of employee

Group/policy name	Group/policy number	Section	ID number

Mailing address of employee	City/town	Province	Postal code

Home phone number	Work phone number	Cell phone number	Email address

Date employed (YYYY-MM-DD)	Is the employee actively at work? ☐ Yes ☐ No	If no, what is the date last worked and explain the reason the employee discontinued work? (YYYY-MM-DD)

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

Signature	Name (please print)	Date (YYYY-MM-DD)

Position	Phone number	Fax number	Email address

2. To be completed by employee (plan member)

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)

Date of onset of illness (YYYY-MM-DD)	Have you had this illness before? ☐ Yes ☐ No	If yes, when? (YYYY-MM-DD)

Describe the illness

Have you ever received payment of Critical Illness benefit under your group plan? ☐ Yes ☐ No	If yes, for what illness/condition?	Date when you received CI benefit payment (YYYY-MM-DD)

Medical information

Provide the names of any physician, medical practioner, care provider or hospital that has treated you.

Provider or hospital	First date (YYYY-MM-DD)	Last date (YYYY-MM-DD)	Next 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 generic 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 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.