ALBERTA BLUE CROSS®

GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM

10009 108 Street NW, Edmonton, Alberta T5J 3C5
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Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

Instructions
1. Read, complete and sign this side of the form.
2. Arrange for the physician to complete the reverse side.

Submit directly to Alberta Blue Cross, Life & Disability Services (see contact information above).

Employer statement

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

Group/policy name	Group/policy number	Section	ID number	Employee last day of work (YYYY-MM-DD)

Mailing address of employee	City or town	Province	Postal code

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

Name	Position or title

Phone	Fax	Email

Signature	Date (YYYY-MM-DD)

Plan member statement

Name of claimant (if not the plan member)	Relationship to plan member	Birth date of claimant (YYYY-MM-DD)

Date of accident (YYYY-MM-DD)	Time	Where did it happen?
	☐ a.m. ☐ p.m.	☐ Home ☐ Work ☐ Elsewhere (please specify)

How did the accident happen? Please give complete description. Please use back of form for additional space.

I am claiming dismemberment benefits due to the loss of

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can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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

Phone	Email

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

Authorization and consent to release this information is provided on the front of this form.
The member is responsible for submitting this completed form and accepting any charges for its completion.

Physician statement

Patient's name | Age

1. Date of accident (YYYY-MM-DD) | Nature of accident

Was the injury self-inflicted? ☐ Yes ☐ No Describe

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 so, please give details of contributory causes.

2. Date of first treatment following accident (YYYY-MM-DD) | Date of last treatment following accident (YYYY-MM-DD)

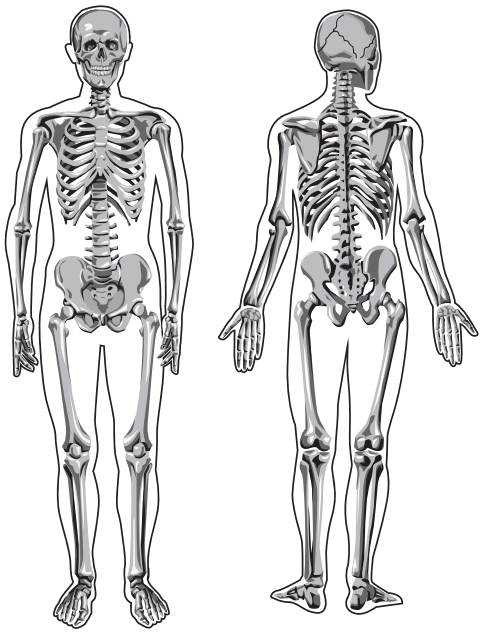
Was the patient treated in hospital? ☐ Yes ☐ No | Name of hospital

Date of hospital treatment
Outpatient (YYYY-MM-DD) **or** **Inpatient admission** (YYYY-MM-DD) **Discharge** (YYYY-MM-DD)

Surgical treatment, if any (YYYY-MM-DD) | Details

Are you aware of any other physicians who treated this patient due to the accident? ☐ Yes ☐ No If yes, please give names and addresses.

If the accident caused the loss of hand, arm, leg or foot, indicate on the chart the level of amputation or loss of use.



Did the accident result in				A. Loss of use of	B. Amputation of (where applicable)	C. Date of loss (YYYY-MM-DD)
Loss of hand	☐ Left	☐ Right	☐ Both	☐	☐	
Loss of foot	☐ Left	☐ Right	☐ Both	☐	☐	
Loss of arm	☐ Left	☐ Right	☐ Both	☐	☐	
Loss of 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	☐	☐	
Loss of speech						
Loss of hearing	☐ Left	☐ Right	☐ Both	☐	☐	
Loss of sight (20/200)	☐ Left	☐ Right	☐ Both	☐	☐	

Is the patient				Is the loss total and irrecoverable? ☐ Yes ☐ No
	1) Quadriplegic	☐ Yes	☐ No	
	2) Paraplegic	☐ Yes	☐ No	
	3) Hemiplegic	☐ Yes	☐ No	

Remarks

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) | Signature of physician | Date (YYYY-MM-DD)

Address | Phone | Fax