ALBERTA BLUE CROSS®

TERMINAL ILLNESS CLAIM FORM

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

If you are diagnosed with a terminal illness with a life expectancy of less than 12 months and have an eligible policy, you could qualify for a one-time advance payment of up to 50% of your policy's benefit to a maximum of $50,000. The special advance payment will be deducted from the Employee Life Insurance benefit. Please be advised that this benefit is only available to the Member of the policy.

EMPLOYER STATEMENT

Group/policy name	Group/policy number	Section

Employee (plan member) name	Identification number

Life coverage effective date (YYYY-MM-DD)	Date employed (YYYY-MM-DD)	Annual salary

Is employee actively at work? ◯ Yes ◯ No	If No, please explain the reason this employee discontinued work:
If No, date last worked (YYYY-MM-DD)	

Please provide a copy of <u>all</u> beneficiary designation records available.

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

Name	Position or title	Phone number

Email address	Signature	Date (YYYY-MM-DD)

CLAIMANT STATEMENT

Employee (plan member) name	Date of birth (YYYY-MM-DD)

Address	City	Postal code

Phone number	Email address

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) only when needed for a purpose stated above. 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I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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 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**.

Claimant signature	Date (YYYY-MM-DD)

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

ALBERTA BLUE CROSS®

ATTENDING PHYSICIAN STATEMENT
TERMINAL ILLNESS CLAIM FORM

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

PART 1: Patient Authorization

Patient name	Date of birth (YYYY-MM-DD)

I hereby authorize the release to my insurer of any information in respect of this application.

Patient signature	Date (YYYY-MM-DD)

PART 2: Attending Physician Statement
TO BE COMPLETED BY THE DOCTOR

DIAGNOSIS

In your opinion, what is your patient's life expectancy? (mandatory)

A) Primary diagnosis

B) Secondary diagnosis

C) Additional conditions or complications

Date symptoms appeared (YYYY-MM-DD)

Please provide any additional information or medical documentation that would be relevant to support this application:

Physician name		Address		
City	Province	Postal code	Phone number	Fax number

Physician signature	Date (YYYY-MM-DD)