MANITOBA BLUE CROSS®

Case Management Services

APPLICATION FOR CRITICAL CONDITION BENEFIT

Submit directly to Manitoba Blue Cross, Case Management Services.
Fax: 204.788.5591 Email: LDinfo@mb.bluecross.ca Mail: PO Box 1046 Stn Main, Winnipeg MB R3C 2X7

EMPLOYER'S STATEMENT

Employee's Name (last name, first name)	Policy Number	Certificate Number

Effective date of employee's coverage (yyyy-mm-dd)	Employee Class	Does employee have family coverage? Yes ☐ No ☐	Date Employed (yyyy-mm-dd)

Is coverage still in force?

Yes ☐ No ☐ If no, date cancelled (yyyy-mm-dd) _____ Reason Cancelled _____

Is employee actively at work?

Yes ☐ No ☐ If no, what is date last worked? (yyyy-mm-dd) _____

Please explain the reason this employee discontinued work

I declare the answers to the questions above are true and complete

Name of Authorized Person (print) | Job Title | Telephone Number (include area code)

Signature of Authorized Person | Date (yyyy-mm-dd)

CLAIMANT'S STATEMENT

Claimant's Name (last name, first name)	Date of Birth (yyyy-mm-dd)	Telephone Number (include area code)

Claimant's Mailing Address (street, city, province, postal code)	Email Address

Claimant's relationship to the employee	Date symptoms first appeared, condition onset	Have you ever had this condition before?
Employee ☐ Spouse ☐ Dependent ☐	(yyyy-mm-dd) _____	Yes ☐ No ☐ When? (yyyy-mm-dd) _____

Describe the condition

_____

_____

Please give name(s) of all medical practitioners who treated you for this condition

_____

_____

Hospital(s) or Facility(s) in which you were treated

Authorization and Consent

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company's business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross's privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

A photostatic copy of this authorization shall be as valid as the original.

Employee (Member) signature or electronic printed name	Date (yyyy-mm-dd)