

Member Name (Please Print):

Certificate Number:

With respect to the decision of Manitoba Blue Cross to deny or close my claim for **life and/or disability benefits** which are underwritten by the Blue Cross Life Insurance Company of Canada, I hereby file notice of my intent to appeal for:

- ☐ Reconsideration / First Level of Appeal
☐ Reconsideration / Second Level of Appeal

I understand it is my responsibility to provide Manitoba Blue Cross with new and relevant information for this level of appeal.

In support of my appeal, I will provide the following information:

- ☐ A written statement of circumstances
☐ Medical information:

- ☐ Other:

Signed:

Member Signature

Date:

YYYY-MM-DD

Submit your Notice of Appeal and supporting information to:

**Manitoba Blue Cross
Case Management Services**

599 Empress Street
PO Box 1046 Stn Main
Winnipeg MB R3C 2X7

Email: LDinfo@mb.bluecross.ca

Fax: 204.788.5591