MANITOBA BLUE CROSS®

OVER-AGE DEPENDENT DECLARATION

Certificate Number _____ Client Number _____

PART 1 - MEMBER AND DEPENDENT INFORMATION

Member	First Name	Last Name	Birthdate (dd/mm/yyyy)
Dependent	First Name	Last Name	Birthdate (dd/mm/yyyy)

Natural Child ☐ Other (Please Specify)

Please note if you have an approval letter from Canada Revenue Agency authorizing the dependent with a disability, we will accept that in place of this form for the dates indicated on the letter. In absence of an approval letter from CRA, please fill in the remainder of the form below.

PART 2 - MEMBER TO COMPLETE: If more space is needed, use Part 4 - Additional Information on page 2

1. Is the dependent fully supported by you? Yes ☐ No ☐
2. Does the dependent reside with you? Yes ☐ No ☐

If no, indicate where the dependent lives: _____

3. Is the dependent married, or common law and/or self-sustaining employment? Yes ☐ No ☐
4. Does the dependent have any other privately/publicly funded health benefits? Yes ☐ No ☐

If yes please give details:

5. Does the dependent have a source of income? Yes ☐ No ☐

If yes, give details:

6. Is this condition due to third party liability? Yes ☐ No ☐

If yes, are expenses being covered by the third party medical?

PART 3 - ATTENDING PHYSICIAN TO COMPLETE: If more space is needed, use part 4 - Additional Information on page 2

1. Specific diagnosis of illness & condition (indicate the extent or severity and the current level of function):
2. How long has the illness or condition been present?

(dd/mm/yyyy) _____

3. Is the illness temporary? Yes ☐ No ☐
4. Is the dependent capable of working and/or self-sustaining employment? Yes ☐ No ☐

If no, do you anticipate a fundamental or marked changed in the patient's condition in the future? Yes ☐ No ☐

If yes, when will the patient recover sufficiently to be capable of self-support?

(dd/mm/yyyy) _____

5. Date dependent was last treated/seen (dd/mm/yyyy) _____

Physician's Name (please print)	Physician's area of specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone Number (include area code)	Date (dd/mm/yyyy)	
Physician's Signature		

I authorize any physician or other health care provider that has diagnosed or rendered treatment for the above named dependent to provide Manitoba Blue Cross full information relating to such diagnosis or treatment. I represent that to the best of my knowledge the statements and answers made by me on this form are complete and correct. I understand and agree that it is my responsibility to advise the insurer should my dependent no longer qualify for coverage as a disabled dependent.

Member's Signature	Date (dd/mm/yyyy)	Phone Number

PART 4 - ADDITIONAL INFORMATION

Submit your Application

By MAIL
PO BOX 1046 STN MAIN
WINNIPEG MB R3C 2X7

IN PERSON
599 EMPRESS ST
WINNIPEG MB

BY FAX
204.772.1231

BY EMAIL
info@mb.bluecross.ca

AUTHORIZATION & 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.