MANITOBA BLUE CROSS®

599 Empress Street
PO Box 1046 Stn Main
Winnipeg MB R3C 2X7
Fax 204.788.5591

APPLICATION FOR BENEFITS
Employee's Statement

To be completed by the insured member.
Submit directly to Manitoba Blue Cross, Case Management Services. See contact information above.

Name of your Employer	Select applicable plan(s) ☐ Weekly Indemnity (Short Term Disability) ☐ Long Term Disability ☐ Waiver of Premium
Your Position/Job Title (as of the last day that you worked)	

Employee (Member) Identification

Last Name	First Name	Middle Name or Initial

Policy ID (5 digit number)	Certificate Number	Social Insurance Number

Birth Date (yyyy-mm-dd) _____	Gender ☐ Male ☐ Female

Employee's Address (Street, City, Province, Postal Code)

Primary Phone Number (include area code) ☐ Home ☐ Cell	Alternate Phone Number (include area code) ☐ Home ☐ Cell

Email Address

Disability Information

What was the last day that you worked? (yyyy-mm-dd) _____

What was the first day that you missed a scheduled day of work? (yyyy-mm-dd) _____

What is the reason that you are off work? e.g. the condition/diagnosis

_____

_____

When did your symptoms first appear? (yyyy-mm-dd) _____

What was the first day that you saw a physician after you stopped working? (yyyy-mm-dd) _____

Were you hospitalized for this condition? ☐ Yes ☐ No If yes, where? _____

Duration of hospitalization From (yyyy-mm-dd) _____ To (yyyy-mm-dd) _____

How does your condition impact your ability to perform your work duties?
i.e. Describe the reason(s) this condition is preventing you from working.

_____

_____

_____

Have you ever had a similar condition? ☐ Yes ☐ No If yes, state when (yyyy-mm-dd) _____ and describe _____

Did it result in an absence from work? ☐ Yes ☐ No If yes, state when (yyyy-mm-dd) _____

Has your physician told you when you can return to work? ☐ Yes ☐ No

Date of return to work (yyyy-mm-dd) _____

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What is the cause of your condition? ☐ illness ☐ accident ☐ occupational illness* ☐ workplace accident* ☐ vehicle accident*

** If your work absence is caused by occupational illness, workplace accident or vehicle accident, please attach the claim made to your provincial workers' compensation board or other relevant organization. A copy of all correspondence with these organizations will also be required.*

For an accident, provide the following information.

Date (yyyy-mm-dd) _____ Time _____ Cause/Circumstances _____

Location _____ Names of witnesses _____

Police report ☐ Yes ☐ No *If yes, attach a copy.*

Medical Information

Height _____ ☐ feet/inches ☐ centimeters Weight _____ ☐ pounds ☐ kilograms Dominate Hand ☐ left ☐ right

After you stopped working, provide information of any physician, medical practitioner or care provider that you have consulted.
(*attach a list if insufficient space)*

Provider _____ First Date _____ Last Date _____ Next Date _____

Provider _____ First Date _____ Last Date _____ Next Date _____

Provider _____ First Date _____ Last Date _____ Next Date _____

Describe your current treatment plan.

_____

_____

_____

Did you undergo or are you waiting for tests, treatments, consultations or surgery? ☐ Yes ☐ No

If yes, provide details _____

_____

_____

_____

List any current medication (prescription or non-prescription) that you are taking at this time.
(*attach a list if insufficient space)*

Name of Medication	Start Date	Last Date of Change	Current Dosage	Frequency

Medical History

List any other health related condition that you may have at this time.

_____

_____

_____

Indicate all physicians or medical practitioners consulted, reason for consultation, and treatment (in the past 3 years).
(*attach a list if insufficient space)*

Physician's Name	Specialty	Address/Phone Number	Reason for Consultation	Treatment/Medication

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Other Sources of Income *(since your last day worked)*

Have you applied for any other benefits, such as Workers Compensation Board, automobile insurance, employment insurance, private or public pension, etc.? ☐ Yes, Carrier _____ ☐ No

If yes, indicate the date of application, claim/file number, decision, and claim/file status. *(attach applicable correspondence)*

_____

Have you received any sources of income since being continuously off work? ☐ Yes ☐ No

If yes, identify the source, amount and period of payment

☐ Salary Continuation ☐ Paid Sick Leave ☐ Paid Vacation ☐ Employment Earnings

☐ Other _____

From (yyyy-mm-dd) _____ To (yyyy-mm-dd) _____

General Remarks

Provide any additional information which may be of value in consideration of this claim.

_____

_____

_____

_____

_____

_____

_____

_____

Employee's Declaration

I understand that it is an offense to make a false or misleading statement in an application for benefits and declare that the answers to the above questions are true and complete.

I understand that Manitoba Blue Cross requires all application documentation before my claim will be adjudicated. An application includes: the Employee's Statement (including authorization and consent), the Attending Physician's Statement (including supporting medical information) and the Employer's Statement (including description of job duties).

I understand it is my responsibility to submit a complete application, provide proof of my claim, and that I am responsible for any fees related to the completion of my application. Missing information could result in delayed adjudication or denial of my claim.

I authorize that, if required by other third parties, my Social Insurance Number may be used by any provider or administrator of my group benefits plan as my personal identification.

I agree to notify Manitoba Blue Cross, Case Management Services, of any changes that may affect my eligibility for benefits. This includes an improvement in my medical condition, a return to work, or entry into treatment or rehabilitation programs.

I have read the above and agree. _____ _____

Signature of Employee (Member) Date (yyyy-mm-dd)

PLEASE SIGN AND DATE THE "Authorization and Consent" FOUND ON PAGE 4

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Authorization and Consent

COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

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 my personal information and personal health information will be kept confidential and secure. 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' privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or at www.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.

_____ _____

Signature of Employee (Member) Date (yyyy-mm-dd)

_____

Please print name of person signing above