

## 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 <input type="checkbox"/> No <input type="checkbox"/>	Date Employed (yyyy-mm-dd)
Is coverage still in force? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, date cancelled (yyyy-mm-dd) _____ Reason Cancelled _____			
Is employee actively at work? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	Date symptoms first appeared, condition onset (yyyy-mm-dd) _____	Have you ever had this condition before? Yes <input type="checkbox"/> No <input type="checkbox"/> 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		

I have read and understand the attached Authorization and Consent.  
 I understand it is an offense to make a false or misleading statement in a claim for benefits and declare the answers to the questions above are true and complete.  
 I understand it is my responsibility to submit a complete claim, and that I am responsible for any fees related to the completion.  
 I understand that Manitoba Blue Cross requires all documentation before my claim will be adjudicated. Missing information can result in delayed adjudication or denial of my claim.  
 I understand this Declaration is valid for the duration of my claim.

**I have read the above and agree**

Signature of Claimant	Date (yyyy-mm-dd)
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## **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](http://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.