BLUE CROSS® CANASSURANCE

# Critical Illness Claim Form

## Claimant's Statement

**The form must be submitted to the insurer within 90 days of the diagnosis.**

## IDENTIFICATION

Claimant's Name: _____ Policy No.: _____

Date of Birth: day/month/year Public Health Card No.: _____

Address: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Name of the policyholder: _____

## INFORMATION ON THE ILLNESS

1. Which illness do you suffer from? _____

2. Date of the first consultation for this condition: day/month/year

3. When you were advised of the diagnosis: day/month/year

4. Name and address of the doctor who diagnosed the illness: _____

_____

5. Name and address of your treating doctor, if different: _____

_____

6. Name and addresses of all doctors consulted in the past two years:

| Name of the doctor | Address | Date of the first consultation | Date of the last consultation | Diagnosis |
|---|---|---|---|---|
| | | day/month/year | day/month/year | |
| | | day/month/year | day/month/year | |
| | | day/month/year | day/month/year | |
| | | day/month/year | day/month/year | |

7. Did you ever suffer from this illness or a similar condition? ❑ yes ❑ no
   If yes, please specify and give details about the condition: _____

_____

8. Have you been hospitalized because of this illness? ❑ yes ❑ no
   If yes, please specify the dates and locations:
   From day/month/year to day/month/year Hospital: _____
   From day/month/year to day/month/year Hospital: _____
   From day/month/year to day/month/year Hospital: _____
   From day/month/year to day/month/year Hospital: _____

## STATEMENT

**I hereby certify that the above information is, to the best of my knowledge, true and complete.**

_____ day/month/year

Signature of insured Date

_____ day/month/year

Signature of policyholder if the insured person in less that 16 years of age in Ontario or less than 14 years of age in Québec. Date

Please read carefully the IMPORTANT NOTICE on the back of this form.

# Important Notice

The forms gathered in this document are required if when a claim is filed for **Critital Ilness** benefit and must be submitted to the insurer within 90 days of the diagnosis.

**CLAIMANT'S STATEMENT**

- It is important to complete all sections and to anwser to all of the questions of the form.
- Attach the TREATING PHYSICIAN'S STATEMENT form and, if need be, the MEDICAL STATEMENT to the claim form.

**TREATING PHYSICIAN'S STATEMENT**

- The IDENTIFICATION section must be completed by the insured person and the form must be completed by the physician.
- A photocopy of the clinical notes or tests results (ex.: imaging result) must be attached to the completed form.
- Attach the MEDICAL STATEMENT if there were any treatments received in clinic, nursing care at home or transportation by ambulance.
- Fees requested to complete this form are paid by the claimant.

**MEDICAL STATEMENT**

The medical statement must be completed if the insured person received out-patient treatments, nursing care at home or transportation by ambulance.

- Only the section IDENTIFICATION must be completed by the insured person.
- An authorized representative must complete other sections of the form.
- All original bills must be attached.
- Fees requested to complete this form are paid by the claimant.

**Important**

No comments must appear the section completed by the physician and his/her notes must not be modified. To provide any details or comments to the information given, a separate sheet must be used.

**AUTORISATION**

- Read carefully the text of the authorization in order to understand the implications. This form will be used to collect the information required for the process of the claim or to disclose information to third parties.
- All three authorizations must be dated and signed in order to avoid any delay in the process.
- A blue ink ball point pen is preferable for some hospitals may mistake a form signed using black ink for a photocopy.

Forward the claim to the appropriate address according to the province of residence. For any questions, contact the Claims Department by telephone prior to forwarding the claim in order to avoir unecessary delays. Calls to our Claims Department are recorded for training, quality control and verification purposes.

**Blue Cross Canassurance**
**Claims, Life and Disability Insurance**
**Telephone:** 514-286-8302 ou 1 800 300-5002
**Fax:** 514-905-7504 ou 1 877 590-7504

**Address in Ontario**
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
**Email:** claimslife.disability@ont.bluecross.ca

**Address in Québec**
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
**Email:** claimslife.disability@qc.bluecross.ca

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# Critical Illness

## Attending Physician Statement

**This form must be submitted to the insurer within 90 days of the diagnosis.**

**PATIENT'S IDENTIFICATION** (to be completed by the claimant)

Name: _____ First name: _____

Date of Birth: ____day/month/year____ Policy No.: _____ Public Health Card No.: _____

**ATTENDING PHYSICIAN'S STATEMENT** (to be completed in block letters and given to the patient)

**DIAGNOSIS**

1. Primary diagnosis: _____ Code CIM-9: _____
2. Secondary diagnosis: _____ Code CIM-9: _____
3. Date of the onset of the symptoms: ____day/month/year____
4. Date of the diagnosis: ____day/month/year____
5. Has the patient ever suffered from this illness or a similar condition? ❑ yes ❑ no
   If yes, please provide details and date: _____
   _____ day/month/year
6. Subjective symptoms: _____
7. Symptômes objectifs (résultats récents de radiographies, ECG, analyses de laboratoire, etc.): _____
   _____
8. Pertinent medical history: _____
9. Prognosis: _____
10. If a stroke occured, were there any presence of neurological after-effects 30 days after the ACV? ❑ yes ❑ no
11. Is the patient affected with AIDS, ARC OR any illness related to an HIV positive result? ❑ yes ❑ no
12. Did the patient use any drugs not prescribed by a doctor: _____

**TREATMENT**

1. Prescribed treatment and anticipated duration: _____
   _____
2. Type of surgery and date: _____
   _____ day/month/year

**HOSPITALIZATION(S)**

1. Has the patient been hospitalized? ❑ yes ❑ no If yes, please provide dates and locations.
   From ____day/month/year____ to ____day/month/year____ Hospital: _____
   From ____day/month/year____ to ____day/month/year____ Hospital: _____
   From ____day/month/year____ to ____day/month/year____ Hospital: _____
   From ____day/month/year____ to ____day/month/year____ Hospital: _____

**STATEMENT**

Last Name and First Name: _____ Telephone: _____

Address: _____ Fax: _____

❑ General practitioner ❑ Specialist Please specify: _____ Licence No.: _____

Signature: _____ Date: ____day/month/year____



Note: The claimant must pay any fees requested to complete this form.

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# Critical Illness

## Out-patient Treatments Medical Certificate

**It is the patient's responsibility to have this statement completed by the clinic.**

**PATIENT'S IDENTIFICATION** (section to be completed by the claimant)

Name: _____ First Name: _____

Date of Birth: _____day/month/year_____ Policy No.: _____ Public Health Card No.: _____

**OUT-PATIENT TREATMENTS**

1. Diagnosis: _____

2. Name and address of the out-patient clinic: _____

   _____

3. Treatments received:

   ❑ chemotherapy ❑ radiation therapy ❑ others: _____

4. Dates of treatments

   _____day/month/year_____ _____day/month/year_____ _____day/month/year_____ _____day/month/year_____

   _____day/month/year_____ _____day/month/year_____ _____day/month/year_____ _____day/month/year_____

**STATEMENT**

**I hereby declare that the patient has received the treaments mentioned above.**

_____ _____

Name of the authorized agent, in block letters Telephone

_____ _____day/month/year_____

Signature of the authorized agent Date

Note: The claimant must pay any fees requested to complete this form.

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# Critical Illness

## Home Nursing Care Medical Certificate

**It is the patient's responsibility to have this statement completed by the doctor who prescribed the nursing care at home.**

**PATIENT'S IDENTIFICATION** (section to be completed by the claimant)

Name: _____ First Name: _____

Date of Birth: ____day/month/year____ Policy No.: _____ Public Health Card No.: _____

**HOME NURSING CARE**

1. Diagnosis: _____
2. Name of the hospital: _____
3. It there was a surgery performed, please specify the date: ____day/month/year____ Date of discharge: ____day/month/year____
4. Date of prescription for home nursing care: ____day/month/year____
5. Details of the healthcare to be provided by the nurse: _____
   _____
   _____
6. Indicate if auxiliary nursing care are required only: _____
7. It those nursing care are not covered by the public health plan, why are they required?
   _____
   _____

**STATEMENT**

**I hereby declare that the nursing cares described above are medically required:**

❑ 24 hours/day for_____ days ❑ 16 hours/day for_____ day ❑ 8 hours/day for_____ day ❑ others Specify: ____ hours/day for ____ days

_____ _____

Name of treating doctor, in block letters Telephone

_____ day/month/year

Signature Date

Note: The claimant must pay any fees requested to complete this form.

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# Authorization

## IDENTIFICATION

Name of claimant: _____

Policy No: _____ Date of birth: _____ day / month / year

Name of the policyholder: _____

To assess and determine my eligibility with respect to insurance products and benefits, I hereby authorize any physician, health professional, hospital, medical establishment, insurance company or reinsurer, the Medical Information Bureau (MIB) or other organization, institution, employer, broker, agent, representative or other individual in the possession of information about me or my state of health, including my medical history, to convey or transmit this information to Canassurance Hospital Service Association or Canassurance Insurance Company (hereinafter referred to as the 'Insurer'), or reinsurer, internal or external auditors, as well as any professional or organization mandated by the Insurer for the purpose of processing of my claim.

I hereby authorize Canada Pension Plan (CPP), Québec Pension Plan (QPP), Human Resources and Skills Development Canada (HRSDC), *Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)*, Workplace Safety and Insurance Board of Ontario (WSIB), *Régie de l'assurance maladie du Québec (RAMQ), Société de l'assurance automobile du Québec (SAAQ)* and any other federal or provincial organization or board to convey to the Insurer administrative, medical and pharmacological information about me.

In addition, I hereby authorize the Insurer to share information about me with the aforementioned individuals and organizations. This authorization shall be valid for the duration of my disability claim.

_____ _____ day / month / year

Signature of claimant Date

_____

Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec

01VRS0016A (03-2020)

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

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Policy No: _____ Date of birth: _____ day / month / year

Name of the policyholder: _____

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