SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

STUDENT ACCIDENT CLAIM FORM

This claim form is to be used for claims on death, dismemberment, fracture or dislocation, tutorial and confinement benefits.

INSTRUCTIONS:

- Read your policy carefully to determine the benefits to which you may be entitled
- Complete the claim form clearly, answering all questions
- In the event of death, enclose a death certificate and a copy of the birth certificate
- Submit your claim to Saskatchewan Blue Cross, PO Box 4030, Saskatoon, SK S7K 3T2

PATIENT INFORMATION (Please type or print clearly)

Last Name	First Name	Policy Number
Age	Grade	Telephone Number
Address (Street Number and Name)	Apartment or Suite	City
Province	Country	Postal/Zip Code

Name Of School

Address

Location of Accident

Accident Occurred: ☐ Enroute To/From School ☐ School Grounds ☐ AM ☐ PM

Date of Accident or Death (YYYY/MM/DD)

Describe accident giving all details in order of occurrence (attach sheet if space insufficient):

Describe fully injuries sustained:

Is student presently continuing education? ☐ Yes ☐ No If not, what was last date of attendance? _____ (YYYY/MM/DD)

Is student covered by another insurance plan? ☐ Yes ☐ No If yes, state name of insurance company: _____

Address

Policy Number

To whom is payment to be made?

Name

Relationship to Student

Address

Postal Code

REPORT OF ATTENDING PHYSICIAN

Date patient first treated for injuries resulting from this accident (YYYY/MM/DD)

Date of last treatment (YYYY/MM/DD)

Describe exact nature, location and extent of all injuries sustained:

DISMEMBERMENT AND LOSS OF USE

a) If accident resulted in the dismemberment or loss of use of a body part, include the part(s) lost, level and date of amputation if applicable. Indicated on the chart outlined below:

Did the accident result in:		Loss of Use	Amputation (If Applicable)	Level of Amputation	Date of Loss (YYYY/MM/DD)
Hand	☐ Left ☐ Right ☐ Both	☐	☐		
Foot	☐ Left ☐ Right ☐ Both	☐	☐		
Arm	☐ Left ☐ Right ☐ Both	☐	☐		
Leg	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of thumb and fingers (at or above the first interphalangeal joint)					
Thumb #1	☐ Left ☐ Right ☐ Both	☐	☐		
Index finger #2	☐ Left ☐ Right ☐ Both	☐	☐		
#3	☐ Left ☐ Right ☐ Both	☐	☐		
#4	☐ Left ☐ Right ☐ Both	☐	☐		
Little finger #5	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of toes (at or above the first interphalangeal joint)					
Big toe #1	☐ Left ☐ Right ☐ Both	☐	☐		
#2	☐ Left ☐ Right ☐ Both	☐	☐		
#3	☐ Left ☐ Right ☐ Both	☐	☐		
#4	☐ Left ☐ Right ☐ Both	☐	☐		
Little toe #5	☐ Left ☐ Right ☐ Both	☐	☐		
Other					
Loss of speech	☐ Yes ☐ No	☐	☐		
Loss of hearing	☐ Left ☐ Right ☐ Both	☐	☐		
Loss of sight (20/200)	☐ Left ☐ Right ☐ Both				

b) Is the patient

1) quadriplegic ☐ Yes ☐ No

2) paraplegic ☐ Yes ☐ No

3) hemiplegic ☐ Yes ☐ No

Is the loss total and irrecoverable?

☐ Yes ☐ No

In the event that the injury or disease resulted in the death of the student, please complete the following:

Place of Death

Cause of Death

a) Disease or Condition Leading to Death

b) Antecedent Causes

c) Other Significant Conditions

Was cause of death: ☐ Accident ☐ Suicide ☐ Homicide

Enclose a copy of death certificate, autopsy reports and toxicology analysis.

NOTICE TO PHYSICIAN

The information in this statement will be kept in a life, health or disability benefit file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Attending Physician's Signature

Date (YYYY/MM/DD)

Physician's Address

ACKNOWLEDGMENT & CONSENT

I declare that the answers to the questions on this form are complete and accurate. I understand that the personal information I have provided may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation.

For the above purposes, I authorize any physician, pharmacy, practitioner or other health care provider, hospital, clinic or other medical facility, insurer, employer (past and present), provincial workers compensation plan, medical or benefit payment plan, government or regulatory authority, or other organization, institute or person that has any records or knowledge of me or my health to give Saskatchewan Blue Cross or Blue Cross Life Insurance Company of Canada full particulars of such information, including any prior medical history relevant to this claim and benefits. I further authorize Saskatchewan Blue Cross and Blue Cross Life Insurance Company of Canada to exchange this information with each other, their reinsurers, investigative agencies or to any third party when required for a purpose stated above. Medical information may also be released to my personal physician or other medical practitioner.

I agree and am aware Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may engage a collection agency to collect any overpayment that occurs during the course of my life and/or disability claim.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1-800-USEBLUE®. A photocopy of this authorization shall be as valid as the original.

Claimant Printed Name

Witness Printed Name

Claimant Signature

Witness Signature

Claimant Address

Witness Address