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

APPLICATION FOR BENEFITS
EMPLOYEE STATEMENT

Last Name | First Name | Initial

Sex: ☐ Male ☐ Female ☐ Unspecified

Date of Birth (YYYY/MM/DD)

Provincial Health Card Number

Please attach a copy of drivers license, passport, etc.

Street Address/PO Box | City/Town | Province | Postal Code

Email Address | Telephone

What is the nature of your medical condition? _____

Is your condition due to an accident? ☐ Yes ☐ No

If yes, what was the nature of your accident? ☐ WCB* ☐ Auto* ☐ Other

Provide details and include date (YYYY/MM/DD):

If your work absence is caused by a workplace accident or vehicle accident, please attach the claim made to your provincial workers' compensation board, automobile insurance or other relevant organizations. A copy of all correspondence with these organizations is required.

Were you hospitalized for this condition? ☐ Yes ☐ No

If yes, where (name and location)?

Duration of hospitalization:

From: _____ To: _____

YYYY MM DD YYYY MM DD

List any current medication (prescription or non-prescription) that you are taking at this time. (Please attach a list if more space is required)

Name of Medication	Start Date (YYYY/MM/DD)	Last Date of Change (YYYY/MM/DD)	Current Dosage	Frequency

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

If yes, describe:

Start Date of Treatment (YYYY/MM/DD) | End Date of Treatment (YYYY/MM/DD)

Type of Treatment (For example, chemotherapy, physiotherapy, psychotherapy)

Name of Treatment Provider | Contact Information of Treatment Provider

State the reason (s) this condition is preventing your return to work:

Have you ever had a similar condition? ☐ Yes ☐ No
If yes, state when and provide details:

Do you have any other medical condition(s) at this time? ☐ Yes ☐ No
If yes, describe:

When do you expect to return to work?

Provide the name of the physician who is currently providing treatment for this condition, and the name of all medical practitioners who have treated you in the last 3 years. (Please attach a list if more space is required.)

Physician or Hospital Name and Location	Reason	Date of First Visit (YYYY/MM/DD)	Date of Last Visit (YYYY/MM/DD)

Are you receiving, or have you applied for accident or disability benefits from other sources? (e.g. CPP/QPP, your province's workers' compensation board (WCB), automobile insurance, insurance companies, government agencies, etc.) **If available, please provide a copy of any approval letters you have received.**

Source	Date of Application (YYYY/MM/DD)	Benefit Amount	Frequency (weekly, monthly, etc)	Start Date (YYYY/MM/DD)
CPP/QPP		$		
WCB		$		
Auto Insurance		$		
		$		
		$		

Please describe your current usual daily and weekly activities/routine (including any hobbies or interests)

Provide any additional information which may be of value in consideration of this application for benefits

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.

Signature

Date (YYYY/MM/DD)