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 last name	Claimant's first name	Policy No.
Date of Birth (DD-MM-YYYY)	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 (DD-MM-YYYY)	3. When you were advised of the diagnosis (DD-MM-YYYY)

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 (DD-MM-YYYY)	Date of the last consultation (DD-MM-YYYY)	Diagnosis

7. Did you ever suffer from this illness or a similar condition? ☐ Yes ☐ No	If yes, please specify and give details about the condition (DD-MM-YYYY)

8. Have you been hospitalized because of this illness? ☐ Yes ☐ No If yes, please specify the dates and locations

From (DD-MM-YYYY)	To (DD-MM-YYYY)	Hospital

STATEMENT

I hereby certify that the above information is, to the best of my knowledge, true and complete. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate and/or to obtain your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

Signature of insured _____ Date (DD-MM-YYYY) _____

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 (DD-MM-YYYY) _____

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

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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.

ATTENDING PHYSICIAN 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 test 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.

AUTHORIZATION

- 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** or **1-800-300-5002**

Address in Ontario
P.O. Box 4433, Station A
Toronto, Ontario M5W 3Y7
Secure Website: on.bluecross.ca/depot

Address in Québec
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
Secure Website: qc.bluecross.ca/depot

BLUE CROSS® CANASSURANCE

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)

Last name	First name	Policy No.
Date of Birth (DD-MM-YYYY)	Public Health Card No.	

ATTENDING PHYSICIAN'S STATEMENT (to be completed 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 (DD-MM-YYYY)	4. Date of the diagnosis (DD-MM-YYYY)

5. Has the patient ever suffered from this illness or a similar condition? ☐ Yes ☐ No

If yes, please provide details and date (DD-MM-YYYY)

6. Subjective symptoms	7. Objective findings (recent imaging reports, ECG, lab tests, 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 (DD-MM-YYYY)

HOSPITALIZATION(S)

1. Has the patient been hospitalized? ☐ Yes ☐ No If yes, please provide dates and locations.

From (DD-MM-YYYY)	To (DD-MM-YYYY)	Hospital

STATEMENT

Last name	First name	Telephone
Address		Fax
☐ General practitioner ☐ Specialist	Please specify	Licence No.

Signature _____ Date (DD-MM-YYYY) _____

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

BLUE CROSS® CANASSURANCE

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)

Last name	First name	Policy No.
Date of Birth (DD-MM-YYYY)	Public Health Card No.	

OUT-PATIENT TREATMENTS

1. Diagnosis

2. Name and address of the out-patient clinic

Name		
No.	Street	Apt.
City	Province	Postal code
3. Treatments received ☐ chemotherapy ☐ radiation therapy ☐ others	If others, specify	

4. Dates of treatments

(DD-MM-YYYY)	(DD-MM-YYYY)	(DD-MM-YYYY)	(DD-MM-YYYY)
(DD-MM-YYYY)	(DD-MM-YYYY)	(DD-MM-YYYY)	(DD-MM-YYYY)

STATEMENT

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

Name of the authorized agent

Telephone

Signature of the authorized agent

Date (DD-MM-YYYY)

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)

Last name	First name	Policy No.
Date of Birth (DD-MM-YYYY)	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 (DD-MM-YYYY)	Date of discharge (DD-MM-YYYY)

4. Date of prescription for home nursing care (DD-MM-YYYY)

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_____ days ☐ 8 hours/day for_____ days

☐ others Specify:_____ hours/day for_____ days

_____ _____

Name of attending physician | Telephone

_____ _____

Signature | Date (DD-MM-YYYY)

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

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

Last name of claimant	First name of claimant	Policy No.
Date of birth (DD-MM-YYYY)	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 MIB, Inc. 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 Insurance Company, or Blue Cross Life Insurance Company of Canada (hereinafter jointly 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. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate and/or to obtain your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

Signature of claimant	Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec	Date (DD-MM-YYYY)

01VRS0016A (2024-10)

BLUE CROSS® CANASSURANCE

Authorization

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Date of birth (DD-MM-YYYY)	Name of the policyholder	

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