

EMPLOYEE INFORMATION

Identification No.: _____ Policy No.: _____
 Patient Last Name: _____ Patient First Name: _____
 Address: _____
 Telephone No.: _____ Date of Birth (day/month/year): _____
 Subscriber Last Name: _____ Subscriber First Name: _____

Coordination of Benefits

Do you or any of your dependents have other coverage under any other Plan? Yes No

If Yes, complete the following: Name of other Insurer: _____

Name of Person(s) insured under other policy	Date of Birth		
	Day	Month	Year

Effective Date of coverage: _____

Identification Number: _____

Policy Number: _____

Type of Coverage: Hospital Vision EHB
 Drugs Dental All

Other Information

Is this claim due to an accident? Yes No **If No, please skip to next section.**

Has this accident been reported to Medavie Blue Cross Yes No

If No, complete the following:

1. Did the accident happen as a result of an automobile accident? Yes No
2. Did the accident happen while you were at work? Yes No
 - a) If Yes, has worker's compensation been advised? Yes No
 - b) If Yes, please provide your worker's compensation file no. _____
3. Date of accident _____ Location of accident _____
4. Brief description of accident _____

5. Are the injuries suffered in whole or in part due to the fault of another party? Yes No
 - a) If yes, please indicate the name, address and/or telephone number of your lawyer or the responsible party's insurer/adjuster, and the third party's name and policy number.

EMPLOYEE STATEMENT

I hereby authorize any health care providers to release to Atlantic Blue Cross Care any information that relates to or supports claims submitted on my behalf, and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me*, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature _____ Date _____
 (If under 18 years of age the signature of the subscriber is required.)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

*not applicable in Ontario or Quebec

