

# 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.

\_\_\_\_\_  
 Signature of insured

\_\_\_\_\_  
 Date (DD-MM-YYYY)

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

\_\_\_\_\_  
 Date (DD-MM-YYYY)

## IMPORTANT NOTICE

The forms gathered in this document are required if when a claim is filed for **Critical Illness** 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 answer 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 avoid unnecessary 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](https://on.bluecross.ca/depot)

#### Address in Québec

1981 McGill College Avenue, Suite 105

Montreal, Quebec H3A 0H6

Secure Website: [qc.bluecross.ca/depot](https://qc.bluecross.ca/depot)

# 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 occurred, were there any presence of neurological after-effects 30 days after the ACV? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is the patient affected with AIDS, ARC OR any illness related to an HIV positive result? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> General practitioner <input type="checkbox"/> Specialist	Please specify	Licence No.
Signature		Date (DD-MM-YYYY)

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 <input type="checkbox"/> chemotherapy <input type="checkbox"/> radiation therapy <input type="checkbox"/> 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 treatments 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.

# 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

- Diagnosis
- Name of the hospital
- It there was a surgery performed, please specify the date (DD-MM-YYYY)      Date of discharge (DD-MM-YYYY)
- Date of prescription for home nursing care (DD-MM-YYYY)
- Details of the healthcare to be provided by the nurse
- Indicate if auxiliary nursing care are required only
- 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.

**IDENTIFICATION**

Last name of claimant	First name of claimant	Policy No.
Date of birth (DD-MM-YYYY)	Name of the policyholder	
<p>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 Hospital Service Association, or 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.</p> <p>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.</p> <p>This authorization shall be valid for the duration of my disability claim.</p>		
Signature of claimant		Date (DD-MM-YYYY)
Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec		

01VRS0016A (2022-03)

**IDENTIFICATION**

Last name of claimant	First name of claimant	Policy No.
Date of birth (DD-MM-YYYY)	Name of the policyholder	
<p>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 Hospital Service Association, or 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.</p> <p>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.</p> <p>This authorization shall be valid for the duration of my disability claim.</p>		
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Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec		

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**IDENTIFICATION**

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

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