MANITOBA BLUE CROSS®

Case Management Services

APPLICATION FOR DISABILITY BENEFITS
Employee's Statement

Employee (Member)

Employee's Name ______________________ (Last) ______________________ (First) S.I.N. ______________________

Address ______________________ (Street/Box Number) ______________________ (City) ______________________ (Province) ______________________ (Postal Code)

Date of Birth ______________________ (yyyy-mm-dd) Telephone Number ______________________ (Area Code)

Employed by ______________________ Position on last day worked ______________________

Employment Status ☐ Full Time ☐ PartTime Regularly Scheduled hours of work per week ______________________

Brief description of Regular Job Duties ______________________

____

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____

On your last day worked, are/were you employed in another job aside from your position specified above? ☐ No ☐ Yes

Disability Information

Date present illness began or accident occurred ______________________ (yyyy-mm-dd)

Is illness or accident work-related? ☐ No ☐ Yes

If work-related, have you filed a claim with Workers Compensation? ☐ No ☐ Yes (if Yes, include your claim number) ______________________

First Regularly Scheduled day absent from work, due to present condition ______________________ (yyyy-mm-dd)

If condition is due to injury, please describe when, where and how the injury occurred (include police report number and/or MPI claim number, if applicable)

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____

Describe the specific symptoms which prevent you from performing your Regular Job Duties

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Have you ever had the same or similar condition? ☐ No ☐ Yes (if Yes, give specifics including dates)

____

____

Have you been able to work for salary or profit since the commencement of your present illness/injury? ☐ No ☐ Yes (if Yes, provide details)

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Manitoba Safeway/UFCW Local 832 Health & Welfare Plan
3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1
Phone 204.982.4177 Outside Winnipeg 1.877.982.4177 Fax 204.982.6080

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Medical Information

PROVIDE INFORMATION ABOUT THE PHYSICIAN WHO WILL BE SUBMITTING MEDICAL INFORMATION ON YOUR BEHALF

☐ Family Physician ☐ Specialist - Certified Specialty ____________________

Physician's Name ____________________

Address ____________________ Telephone ____________________ (Area Code)

Date of first visit ____________________ (yyyy-mm-dd) Date of last visit ____________________ (yyyy-mm-dd)

PROVIDE NAMES OF ALL OTHER MEDICAL PRACTITIONERS WHO HAVE TREATED YOU IN THE LAST THREE YEARS

Physician or Hospital	Reason	Date of first visit	Date of last visit

LIST MEDICATION YOU CURRENTLY TAKE

Name of medication	Dosage	How often

Describe other treatment you are receiving (e.g.: counselling, physiotherapy)

____

____

Has your physician told you when you can return to work? ☐ Yes, approximate date ____________________ (yyyy-mm-dd) ☐ No

Other Income

Source	Yes	No	Date Application Submitted	Date Benefits Commenced	Date Benefits Ceased
Sick Benefits					
Workers Compensation					
Employment Insurance					
Canada Pension Plan					
Manitoba Public Insurance					
Other (Specify)					

Employee's Declaration with respect to the Manitoba Safeway/UFCW Local 832 Health & Welfare Plan

I understand I must submit a complete application for benefits within 90 days from my first day absent from work.

I understand it is an offense to make a false or misleading statement in an application for benefits and declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

I understand the Trustees of this Plan reserve the right to deny or terminate benefits and recover any payments made for failure to disclose all relevant information.

I understand Manitoba Blue Cross requires all application documentation before my claim will be adjudicated. An application includes: the Employee's Statement with the attached Authorization and Consent, the Employer's Statement (including a description of my job duties), and the Attending Physician's Statement (including supporting medical information).

I understand it is my responsibility to submit a complete application, provide proof of my claim, and that I am responsible for any fees related to the completion of my application. Missing information could result in delayed adjudication or denial of my claim.

I understand this is a taxable benefit and I authorize that my Social Insurance Number will be used to administer the terms of the Plan.

I agree to notify Manitoba Blue Cross, Case Management Services, of any changes that may affect my eligibility for benefits. This includes an improvement in my medical condition, a return to work, or entry into treatment or rehabilitation programs.

I understand this Declaration is valid for the duration of my claim.

I have read and understand the attached Authorization and Consent. I understand that the attached Authorization and Consent needs to be signed and dated in order for Manitoba Blue Cross to collect my personal information and personal health information.

I have read the above and agree.

____________________ Signature of Employee (Member) ____________________ Date (yyyy-mm-dd)

Authorization and Consent

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as “Blue Cross”) may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company’s business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross’s privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

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

A photostatic copy of this authorization shall be as valid as the original.

____ ______________________

Signature of Employee (Member) Date (yyyy-mm-dd)

____

Please print name of person signing above

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