MANITOBA BLUE CROSS®

Case Management Services

APPLICATION FOR BENEFITS
Employee's Statement

Notice

To be completed by the insured member. We accept submission by

Email	**LDinfo@mb.bluecross.ca**
Fax	**204.788.5591**
Mail	**PO Box 1046 Stn Main, Winnipeg MB R3C 2X7**
In Person/Drop Box	**599 Empress Street, Winnipeg Manitoba**

This application is for (please select)

- ☐ Weekly Indemnity (Short Term Disability)
- ☐ Long Term Disability
- ☐ Waiver of Premium

Employee (Member)

Last Name | First Name | Middle Name

Name of your Employer

Your Position/Job Title (as of the last day that you worked)

Policy ID | Certificate Number | Social Insurance Number

Birth Date (yyyy-mm-dd)

Gender ☐ Male ☐ Female ☐ _____

Employee's Address (Street, City, Province, Postal Code)

Primary Phone Number (include area code) ☐ Home ☐ Cell

Alternate Phone Number (include area code) ☐ Home ☐ Cell

Email Address

Disability Information

What was the last day that you worked? (yyyy-mm-dd) _____

What was the first day that you missed a scheduled day of work? (yyyy-mm-dd) _____

What is the reason that you are off work? i.e. the condition/diagnosis

_____

_____

When did your symptoms first appear? (yyyy-mm-dd) _____

What was the first day that you saw a physician after you stopped working? (yyyy-mm-dd) _____

Were you hospitalized for this condition? ☐ Yes ☐ No If yes, where? _____

Duration of hospitalization From (yyyy-mm-dd) _____ To (yyyy-mm-dd) _____

How does your condition impact your ability to perform your work duties? i.e. the reason(s) this condition prevents work

_____

_____

_____

Have you ever had a similar condition? ☐ Yes ☐ No If yes, state when (yyyy-mm-dd) _____ and describe _____

Did it result in an absence from work? ☐ Yes ☐ No If yes, state when (yyyy-mm-dd) _____

Has your physician told you when you can return to work? ☐ Yes ☐ No

Date of return to work (yyyy-mm-dd) _____

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What is the cause of your condition? ☐ illness ☐ accident ☐ occupational illness* ☐ workplace accident* ☐ vehicle accident*

**If your work absence is caused by occupational illness, workplace accident or vehicle accident, please attach the claim made to your provincial workers' compensation board or other relevant organization. A copy of all correspondence with these organizations will also be required.*

For an accident, provide the following information

Date (yyyy-mm-dd) _____ Time _____ Cause/Circumstances _____

Location _____ Name of witnesses _____

Police report ☐ Yes ☐ No If yes, attach a copy

Medical Information

Height _____ ☐ feet/inches ☐ centimeters Weight _____ ☐ pounds ☐ kilograms Dominate Hand ☐ left ☐ right

After you stopped working, indicate all physicians and treatment providers that you have consulted (*attach a list if insufficient space*)

Name	First Date	Last Date	Next Date

Describe your current treatment plan

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

If yes, provide details _____

List any current medication (prescription or non-prescription) that you are taking at this time (*attach a list if insufficient space*)

Name of Medication	Start Date	Last Date of Change	Current Dosage	Frequency

Medical History

List any other health related condition that you may have at this time

Before you stopped working, indicate all physicians and treatment providers consulted in the past 3 years, reason for consultation, and treatment (*attach a list if insufficient space*)

Name	Specialty	Address/ Phone Number	Reason for Consultation	Treatment Medication/Dosage

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Other Sources of Income (since your Last Day Worked)

Have you applied for any other benefits, such as Workers Compensation Board, automobile insurance, employment insurance, private or public pension, etc.? ☐ Yes, Carrier _____ ☐ No

If yes, indicate the date of application, claim/file number, decision, and claim/file status (attach applicable correspondence)

_____

Have you received any sources of income since being continuously off work? ☐ Yes ☐ No

If yes, identify the source, amount and period of payment

☐ Salary Continuation ☐ Paid Sick Leave ☐ Paid Vacation ☐ Employment Earnings
☐ Other _____

From (yyyy-mm-dd) _____ To (yyyy-mm-dd) _____

General Remarks

Provide any additional information which may be of value in consideration of this claim

_____

_____

_____

_____

_____

_____

_____

Employee's Declaration

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.

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

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 authorize that, if this is a taxable benefit, 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)

Please sign and date the attached "Authorization and Consent"

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