

PLEASE PRINT ALL INFORMATION

SECTION 1 - TO BE COMPLETED AND SIGNED BY PATIENT (PARENT/GUARDIAN)

SECTION A - CLIENT INFORMATION

Subscriber Name _____ Identification No. _____
 Address _____ Policy No. _____
 _____ Tel. _____
 Patient Name _____ Date of Birth (DD/MM/YYYY) _____
 (Please indicate first and last name)

SECTION B - COORDINATION OF BENEFITS INFORMATION

Do you or your dependent(s) have other coverage provided under any other plan? Yes No **If No, skip to Section C.**
If Yes, complete the following: Name of other insurer: _____

Name of Person(s) insured under other policy	Date of Birth			Effective Date of Coverage _____
	DD	MM	YYYY	
				Identification No. _____
				Policy No. _____
				Type of coverage:
				<input type="checkbox"/> Hospital <input type="checkbox"/> Vision <input type="checkbox"/> EHB
				<input type="checkbox"/> Drugs <input type="checkbox"/> Dental <input type="checkbox"/> All

SECTION C - ADDITIONAL INFORMATION

Is this claim due to an accident? Yes No **If No, skip to Section D.**
 Has this accident been reported to Medavie Blue Cross Yes No

- If No, complete the following:**
- Did the accident happen as a result of an automobile accident? Yes No
 - Did the accident happen while you were at work? Yes No
 - If Yes, has worker's compensation been advised? Yes No
 - If Yes, please provide your worker's compensation file no. _____
 - Date of accident _____ Location of accident _____
 - Brief description of accident _____

 - Are the injuries suffered in whole or in part due to the fault of another party? Yes No
 - 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.

SECTION D - PATIENT (PARENT/GUARDIAN) STATEMENT

I hereby authorize any health care provider to release to Medavie Blue Cross any medical information about me and my dependents which relates to claims submitted by us, or on our behalf, to Medavie Blue Cross. I hereby certify that the services listed have been rendered and that any information relating to these services, and supporting documentation of this information, may be obtained by Medavie Blue Cross for verification purposes.

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

