MEDAVIE BLUE CROSS™

HOSPITAL CASH PLAN GROUP CLAIM FORM

THIS FORM CAN BE COMPLETED FOR ELIGIBLE MEMBERS WHO HAVE BEEN CONFINED TO A HOSPITAL IN CANADA ON AN INPATIENT BASIS UNDERGOING ACTIVE TREATMENT WHILE INSURED.

BENEFIT CODE 0188

MEMBER INFORMATION - To be completed by member or patient

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY): _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ❍ Yes ❍ No

If yes, signature of member is required for validation: _____

PATIENT INFORMATION - To be completed by member or patient

Patient Name: _____ If dependent is over the age 21: ❍ Special Dependent ❍ Full-time Student

Date of Birth (DD/MM/YYYY): _____ If Student, School Name: _____

Address: _____

Relationship to Member: ❍ Self ❍ Spouse ❍ Dependent Telephone Number: _____

MEMBER STATEMENT

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 (Blue Cross Life), 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 Medavie Blue Cross and/or Blue Cross Life'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 Medavie Blue Cross and/or Blue Cross Life organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the member 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 Medavie Blue Cross and/or Blue Cross Life 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 and/or Blue Cross Life to collect, use and disclose my personal information as described above.

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

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

ATTENDING PHYSICIAN'S STATEMENT (Any charge for completing this form is the patient's responsibility.)

Date of Admission*: _____ Date of Discharge*: _____

Name of Hospital: _____ Telephone No.: _____

Address: _____ Postal Code: _____

Was hospitalization due to: ❍ an accident ❍ sickness ❍ or maternity?

Was the patient receiving active treatment? ❍ Yes ❍ No

If Yes, period of treatment: From _____ To _____

Diagnosis: _____

When did this patient first show any symptoms related to this diagnosis? (DD/MM/YYYY) _____

***Please attach a copy of the discharge summary for the admission and discharge dates indicated above.**

Name of attending physician: _____ Telephone No.: _____
(please print)

Physician Signature: _____ Date: _____

SUBMISSION INSTRUCTIONS

Please submit your completed form directly to belairdirect, your Plan Administrator. You may submit by:

Mail:
belairdirect
Attention: Linda MacKenzie
20 Hector Gate, Suite 200, Dartmouth, Nova Scotia B3B 0K3

Email:
GroupBenefitsNS@belairdirect.com
Attention: Linda MacKenzie