BLUE CROSS CANASSURANCE

Claim Form
Accidental Fracture
Claimant's Statement

The form must be submitted to the insurer within 90 days of the accident.

IDENTIFICATION

Claimant's Name: _____ Policy No.: _____

Date of Birth: ___day/month/year___ Public Health Insurance Card No.: _____

Address: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Name of the policyholder: _____

ACCIDENT INFORMATION

Please provide as many details as possible.

Date: _____day/month/year_____ Time: _____ : _____ ❑ AM ❑ PM

Location of accident (Indicate, if possible, street address and type of location: residence, public building, roadway, job site, etc.):

_____

_____

Circumstances (Explain how the accident occurred): _____

_____

_____

Name(s) of witnesses: _____

_____

In case of a road accident, has a claim been filed with another insurance company, public or private? ❑ Yes ❑ No

If yes, please provide:

Name of the insurer: _____ File number (if known): _____

Name(s) of witnesses: _____

Was a police report provided? ❑ Yes ❑ No If yes, please attach a copy.

PERSONAL INFORMATION STATEMENT

I hereby certify that the above information is, to the best of my knowledge, true and complete. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate and/or to obtain your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

_____ _____day/month/year_____

Signature of claimant Date

_____

Signature of the policyholder if claimant is less than 16 years of age in Ontario or less than 14 years of age in Québec.

Please read the IMPORTANT NOTICE on the back of the form.

IMPORTANT NOTICE

The forms gathered in this document are required when a claim is filed for the **Accidental Fracture** benefit.

All questions must be answered and the form must be submitted to the insurer within 90 days of the accidental loss.

CLAIMANT'S STATEMENT
- Sections IDENTIFICATION, ACCIDENT INFORMATION and STATEMENT must be completed.
- If a claim has been filed with another insurer, public or private, provide the relevant information in the section ACCIDENT INFORMATION.
- Fees requested to complete this form are paid by the claimant.

ATTENDING PHYSICIAN'S STATEMENT
- If your doctor completed a form for a disability claim, there is no need to have this form completed.
- The section IDENTIFICATION must be completed by the insured person and the form must be completed by the physician.
- A photocopy of the imaging reports must be attached to the completed form.
- Fees requested to complete this form are paid by the claimant.

Important
No comments must appear in 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 the content of the authorization carefully 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 as some hospitals may mistake a form signed using black ink for a photocopy.

Forward the claim to the appropriate address according to your 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: 1 800-300-5002

Address in Ontario
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
Secure Website: on.bluecross.ca/depot

Address in Québec
1981 McGill College Avenue, Suite 105
Montreal, Quebec H3A 0H6
Secure Website: qc.bluecross.ca/depot

BLUE CROSS CANASSURANCE

Accidental Fracture

Attending Physician's Statement

PATIENT'S IDENTIFICATION (section to be completed by the claimant)

Last Name: _____ First Name: _____

Date of Birth: ____day/month/year____ Public Health Insurance Card No.: _____

ATTENDING PHYSICIAN'S STATEMENT (to be completed in block letters and given to the patient)

DIAGNOSTIC

1. Primary: _____ Code CIM-9: _____

2. Secondary: _____ Code CIM-9: _____

3. Date of the accident: ____day/month/year____

4. Date of the first consultation for the fracture: ____day/month/year____

5. Please provide details about the factured bone(s) and attach a copy of pertinent imaging reports.

   _____

   _____

6. To your knowledge, does this patient suffer from any illness susceptible to have caused the fracture, in whole or in part? ❑ yes ❑ no

   If yes, what condition(s) is the patient suffering from? _____

   Since when? ____day/month/year____

Other comments: _____

_____

_____

STATEMENT

First and Last Name: _____ Telephone: _____

Address: _____ Fax: _____

❑ General practitioner ❑ Specialist Specify: _____ Licence No.: _____

_____ ____day/month/year____

Signature Date

Note: The claimant must pay any fees to complete this form.

BLUE CROSS® CANASSURANCE

Authorization

IDENTIFICATION

Name of claimant: _____

Policy No: _____ Date of birth: _____ day / month / year

Name of the policyholder: _____

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 (hereinafter 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.

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. This authorization shall be valid for the duration of my disability claim. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate and/or to obtain your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.

Signature of claimant	Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec	Date (day / month / year)

01VRS0016A (2023-09)

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