



**CANADIAN PACIFIC CLAIM FORM FOR
EXTENDED HEALTH CARE PLAN FOR PENSIONERS / RETIREES
ALL THE INFORMATION GIVEN ON THIS FORM IS CONFIDENTIAL**

MEMBERS

BRITISH COLUMBIA
PO Box 7000
4250 CANADA WAY
BURNABY (BRITISH COLUMBIA)
V6B 4E1
(604) 419-2000

SASKATCHEWAN
516 SECOND AVENUE NORTH
BOX 4030
SASKATOON (SASKATCHEWAN)
S7J 3T2
(306) 244-2662

MANITOBA
POST OFFICE BOX 1046
WINNIPEG (MANITOBA)
R3C 2X7
(204) 775-0151

QUÉBEC
PO BOX 3300, POSTAL STATION B
1981 MCGILL COLLEGE AVE, SUITE 100
MONTREAL QC
H3B 4Y5
(514) 286-8430

ALBERTA
PO Box 2318 STN Main
Edmonton AB
T5J 0L8
(780) 498-8802

ONTARIO
POST OFFICE BOX 2000
185 THE WEST MALL, SUITE 1200
ETOBICOKE (ONTARIO)
M9C 5P1
(416) 626-1646

ATLANTIC CANADA
POST OFFICE BOX 220
644 MAIN STREET
MONCTON (NEW BRUNSWICK)
E1C 8L3
(506) 853-1811

PLEASE COMPLETE AND MAKE NECESSARY CORRECTIONS TO YOUR ADDRESS

NAME _____

ADDRESS _____

_____ POSTAL CODE _____

NAME OF PARTICIPANT

CONTRACT NO.

SECTION NO.

IDENTIFICATION NO.

- * PLEASE FILL OUT THIS FORM AND ENCLOSE ORIGINAL COPIES OF YOUR BILLS AND RECEIPTS. **THESE DOCUMENTS WILL NOT BE RETURNED. DUPLICATES SHOULD BE RETAINED FOR YOUR FILE.**
- * PLEASE SUBMIT YOUR CLAIM, WITHIN TWELVE (12) MONTHS FROM THE DATE EXPENSES HAVE BEEN INCURRED (UNLESS OTHERWISE STIPULATED IN YOUR CONTRACT).
- * PLEASE SEND THE COMPLETED FORM TO THE BLUE CROSS OFFICE SERVING THE PROVINCE IN WHICH YOU RESIDE. THE OFFICES ARE LISTED ABOVE.

ARE EXPENSES SUBMITTED COVERED BY ANY OTHER INSURANCE CONTRACT? YES NO

IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? YES NO

IF YES: _____
CONTRACT NUMBER INSURER'S NAME

N.B.: THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT HIS CLAIM TO HIS INSURER. AFTERWARDS, PROVIDE BLUE CROSS WITH A COPY OF YOUR RECEIPTS WITH A DETAILED ACCOUNT OF BENEFITS PAID. FURTHERMORE, CLAIMS FOR CHILDREN MUST BE SUBMITTED TO THE INSURER OF THE PARENT (FATHER OR MOTHER) WHOSE BIRTHDAY OCCURS FIRST IN THE CALENDAR YEAR.

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Blue Cross 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 the Company'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 Plans, health care professionals or institutions, health and life insurers, government and regulatory authorities, the cardholder of any contract under which I am a participant, and other third parties when required to administer the benefits outlined in my policy or the group 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, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 1-888-873-9200 should I have questions as to the collection, use or disclosure of my personal information.

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

Signature _____

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws.

IF YOU ARE CLAIMING FOR A DEPENDENT CHILD (AGED 18 OR 21 AND OVER BUT UNDER 25) PLEASE PROVIDE THE FOLLOWING INFORMATION:

GIVEN NAME	NAME OF SCHOOL, COLLEGE OR UNIVERSITY BEING ATTENDED	SEMESTER	FULL TIME	PART TIME

* PLEASE INDICATE THE TOTAL AMOUNT SUBMITTED FOR EACH PATIENT, PER CALENDAR YEAR.

GIVEN NAME	DATE OF BIRTH			SEX	RELATIONSHIP	AMOUNT SUBMITTED	CALENDAR YEAR	FOR BLUE CROSS USE ONLY
	DD	MM	YY					
TOTAL								