CANADIAN PACIFIC CLAIM FORM FOR EXTENDED HEALTH CARE PLAN FOR PENSIONERS / RETIREES

ALL THE INFORMATION GIVEN ON THIS FORM IS CONFIDENTIAL

MEMBERS

Atlantic Provinces	Quebec	Ontario	Other Provinces and Territories
644 Main St PO Box 220	PO Box 3300 STN B	PO Box 2000 STN A	PO Box 2318 STN Main
Moncton NB E1C 8L3	Montreal QC H3B 4Y5	Etobicoke ON M9 C5P1	Edmonton AB T5J 0L8
Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511	Inquiries: 1-800-667-4511

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 Medavie 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 Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life)s 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 Medavie Blue Cross and/or Blue Cross Life 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 Medavie Blue Cross and/or Blue Cross Life's privacy policies I can contact Medavie Blue Cross and/or Blue Cross Life at 1-800-667-4511 should I have questions as to the collection, use or disclosure of my personal information.

I authorize Medavie Blue Cross and/or Blue Cross Life 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.

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Blue Cross Life Insurance Company of Canada underwrites all life and disability benefits.

FORM-277E 07/22

BCARCP REV (07/22)

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 SUB-MITTED	CALENDAR YEAR	**FOR MEDAVIE BLUE CROSS USE ONLY**
	DD	MM	YY					
					TOTAL			

BCAVSA REV (07/22)