PACIFIC BLUE CROSS®

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DISABILITY CLAIM FORM PLAN MEMBER/ EMPLOYEE'S STATEMENT

WWforms@pac.bluecross.ca | Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Fax: 604 419-8055 | Telephone: 604 419-8040 | Toll-Free: 1 888 275-4672

PART 1 — PLAN MEMBER/EMPLOYEE

First name	Last name	Gender* ☐F ☐M ☐U ☐X	Birthdate (mm-dd-yyyy)

Street address	PO box (if applicable)	City	Province	Postal code

Phone number (10 digits)	Social insurance number	Email address

Plan sponsor/employer's name	Policy number	Division	ID number

Job title	Number of years in this job	Plan sponsor/employer's contact name	Plan sponsor/employer's phone number (10 digits)

PART 2 — MEDICAL INFORMATION

Date you became unable to work (mm-dd-yyyy)	Date first able to return to work (mm-dd-yyyy)	Date you first saw a physician after you stopped working (mm-dd-yyyy)

Name and phone number of physician(s):

Name	Phone number (10 digits)	Name	Phone number (10 digits)
1.		2.	

Please describe any limitations and restrictions you have as a result of your medical condition(s):

Describe in detail the way in which your symptoms prevent you from performing any or all of the essential duties of your job:

PART 3 — ACCIDENT INFORMATION

Complete this section if your claim is the result of an accident. Please attach a copy of the police report if applicable.

Date of accident (mm-dd-yyyy)	Time of accident: _____ ☐AM ☐PM	Where did the accident happen?: ☐Work ☐Home ☐Other _____

Describe how the accident happened:

PART 4 — OTHER FINANCIAL INFORMATION

Indicate which benefits you have **applied for, are receiving or expect to receive** from any of the following sources:

SOURCE	AMOUNT	WEEKLY OR MONTHLY	DATE ☐APPLIED FOR	DATE ☐PAYMENT BEGAN
Canada Pension Plan Disability Benefit (attach copy of "Notice of Entitlement" or "Decline letter")	$ _____	☐W ☐M	(mm-dd-yyyy)	(mm-dd-yyyy)
Workers' Compensation	$ _____	☐W ☐M	(mm-dd-yyyy)	(mm-dd-yyyy)
Employment insurance	$ _____	☐W ☐M	(mm-dd-yyyy)	(mm-dd-yyyy)
Automobile insurance	$ _____	☐W ☐M	(mm-dd-yyyy)	(mm-dd-yyyy)
Other (pension plans, STD etc.) specify	$ _____	☐W ☐M	(mm-dd-yyyy)	(mm-dd-yyyy)

*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

PART 5 — EMAIL COMMUNICATION

I authorize PBC to send email communication and attachments to the above provided email address: ☐ Yes ☐ No

If yes, I agree to the following method of communication:
☐ With encryption and password protection
☐ Without encryption or password protection

I understand that email communication and attachments may include confidential and personal information such as medical and financial information involving my claim.

PART 6 — AUTHORIZATION

I certify that the information provided on this form is true and complete to the best of my knowledge and belief.

I understand and consent that the personal information on this form as well as other personal information currently held or collected by Pacific Blue Cross may be collected, used or disclosed to administer the terms of my plan and to assess and process my claim. Some of my personal information may be collected from and/or released to a third party for the purposes listed above. This may include a licensed physician, other medical professionals and medical institutions, investigation agencies, insurers, reinsurers, adjusters, and authorized agents of Pacific Blue Cross.

I authorize Pacific Blue Cross and my plan sponsor and their authorized agents to collect, use and disclose among them my personal information for the purposes described above as well as for planning and managing my rehabilitation and return to work, except for details related to diagnosis, treatment or medication relevant to my claim.

When there is suspicion of fraud and/or plan abuse of my claim, I acknowledge and agree that Pacific Blue Cross may collect, use and disclose information about me pertaining to my claim to any relevant third party, which may include my plan sponsor, regulatory bodies, government organizations, and other insurers, to investigate and prevent fraud and/or plan abuse.

I understand my personal information will be kept confidential and secure. I understand I may revoke my consent at any time by contacting Pacific Blue Cross in writing; however, if I withhold or revoke my consent, my claim may be denied or rescinded. 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.

You may be contacted via the email you provide in order to participate in a Customer Satisfaction Survey for the purposes of evaluating the services we provide to you. Participation in this survey is voluntary.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s).

I agree that a photocopy of this authorization or electronic version is as valid as the original. I understand I am responsible for any fees related to the completion of forms by my physician. For our complete privacy policy, please visit pac.bluecross.ca.

Plan member/employee's name (please print)	ID number
Plan member/employee's signature **X**	Date (mm-dd-yyyy)

PACIFIC BLUE CROSS®

EMAIL YOUR CLAIM
WWforms@pac.bluecross.ca

MAIL YOUR CLAIM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT
604 419-8055

QUESTIONS?
604 419-8040
Toll-free: 1 888 275-4672

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DISABILITY CLAIM FORM
PLAN SPONSOR/ EMPLOYER'S STATEMENT

WWforms@pac.bluecross.ca | Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Fax: 604 419-8055 | Tel: 604 419-8040 | Toll-Free: 1 877 722-2583 (press 1, then 4)

PART 1 — PLAN MEMBER/EMPLOYEE

First name	Last name	Birthdate (mm-dd-yyyy)	Email address

Plan sponsor/employer's name	Policy number	Division	Sub-division (if applicable)	Class	ID number

PART 2 — JOB INFORMATION

Date of hire (mm-dd-yyyy)	Date last worked (mm-dd-yyyy)	Job title as of last day worked

Employee's direct supervisor's name	Phone number (10 digits)	Email address

Why did your employee stop working?

What are the duties in this job, and what percentage of time does each take per week?

Regular number of hours worked per week	Salary paid up to and including (mm-dd-yyyy)	Basic earnings on last day worked and the effective date of those earnings
		$ _____ hourly $ _____ weekly $ _____ monthly (mm/dd/yyyy) _____

Do earnings fluctuate? ☐ Yes ☐ No

Are earnings partially or fully based on commissions? ☐ Yes ☐ No Comments: _____

STD weekly benefit (if applicable)	LTD monthly benefit (if applicable)	Life waiver amount (if applicable)
$ _____	$ _____	$ _____

Does the employee pay 100% of the STD/LTD premium? STD ☐ Yes ☐ No ☐ N/A LTD ☐ Yes ☐ No ☐ N/A

Has the employment been terminated? ☐ Yes ☐ No

If yes, provide date terminated (mm-dd-yyyy)

Reason for termination: _____

Is this absence work related? ☐ Yes ☐ No

Date filed (mm-dd-yyyy)

Provide copies of WCB accident report and available correspondence

Status: _____

If the employee has holidays scheduled, or any type of leave during this absence, please complete the following:		From (mm-dd-yyyy)	To (mm-dd-yyyy)
	☐ Paid sick leave		
	☐ Holidays		
	☐ LOA ☐ Bereavement ☐ Maternity		

If entitled to income other than the above, please explain: _____

As of today, has the employee returned to work? ☐ Yes ☐ No

If yes, provide date returned to work (mm-dd-yyyy) ☐ Full-time ☐ Part-time

If returned to a different position, please specify: _____

If this plan is self-reporting or administered by a Third Party Administrator (TPA*), please provide effective date (mm-dd-yyyy) of applicable coverage under this plan:

STD _____ LTD _____ Life and AD&D _____ Critical Illness _____

Select the benefits the claimant had in force on their date last worked: ☐ Life Insurance ☐ Dependent Life Insurance ☐ AD&D ☐ Critical Illness ☐ Dependent Critical Illness ☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

Have premiums been paid for the above benefits to their date last worked? ☐ Yes ☐ No

For Life Waiver and disability claims, have premiums been/will be continuously paid to the end of the Life Waiver, STD and LTD elimination period? ☐ Yes ☐ No

* For TPA, please provide copy of enrollment and billing statements confirming premiums paid to end of STD and LTD elimination period.

Please note if this section is not completed, proof of coverage will be required.

PART 3 — AUTHORIZATION

I certify that the information provided above is true and complete to the best of my knowledge and belief, and that premiums have been paid as outlined above. I am the ☐ Plan Sponsor/Employer ☐ Third Party Administrator

Authorized official's name (please print)	Phone number (10 digits)	Fax number	Email address

Authorized official's signature	Title	Date (mm-dd-yyyy)
X		

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DISABILITY CLAIM FORM
PHYSICIAN'S STATEMENT

Email: wwforms@pac.bluecross.ca | Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Fax: 604 419-8055 | Telephone: 604 419-8040 | Toll-Free: 1 877 722-2583 (press 1, then 4)

PLAN MEMBERS/EMPLOYEES — Please complete PART 1 of this form.
PHYSICIANS — Please complete PARTS 2 to 4 of this form.

PART 1 — PLAN MEMBER/EMPLOYEE INFORMATION AND CONSENT

First name	Last name	Gender* ☐F ☐M ☐U ☐X	Birthdate (mm-dd-yyyy)

Street address	City	Province	Postal code

Phone number (10 digits)	Height	Weight	Plan sponsor/employer's name

Policy number	ID number	Last date worked (mm-dd-yyyy)	Date returned to work or expected return to work date (mm-dd-yyyy)

I hereby authorize the release of medical and health information in my file to Pacific Blue Cross and/or its authorized reinsurer for the purpose of assessing my disability claim and administering the benefits plan.

This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records.

I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form. For our complete privacy policy, please visit pac.bluecross.ca.

Plan member/employee's signature	Date (mm-dd-yyyy)
X	

PART 2 — PHYSICIAN'S STATEMENT

1. Primary diagnosis:

2. Secondary and/or complications:

3. If childbirth, expected/actual delivery date (mm-dd-yyyy): _____
   ☐ Vaginal ☐ C-Section

4. Occupational illness/injury: ☐ Yes ☐ No
   If yes, date of event (mm-dd-yyyy): _____

5. Automobile accident: ☐ Yes ☐ No
   If yes, date of event (mm-dd-yyyy): _____

6. Date of first visit to you for this condition (mm-dd-yyyy): _____

7. First date of work absence due to condition (mm-dd-yyyy): _____

8. Is/was the patient hospitalized? ☐ Yes ☐ No
   Or had day surgery? ☐ Yes ☐ No
   If yes to either, admittance date (mm-dd-yyyy): _____
   If yes to either, discharge date (mm-dd-yyyy): _____
   Institution name: _____
   If surgery was performed, date of surgery (mm-dd-yyyy): _____
   Description of surgery:

9. Treatment (drug, dosage, physiotherapy, other):

*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

PART 3 — CONTINUATION OF PHYSICIAN'S STATEMENT

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No | If yes, date (mm-dd-yyyy): _____

Treatment provider: _____

Please describe the patient's symptoms including history, severity and frequency:

Frequency of visits? ☐ Weekly ☐ Monthly ☐ Other: _____

Please attach copies of all relevant documents:

- Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- Consultation reports
- Copies of all clinical notes

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of specialist	Specialty	Date of visit (mm-dd-yyyy)

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Do you have concerns about the patient's ability to manage their affairs? ☐ Yes ☐ No

Please provide the prognosis for recovery:

PART 4 — AUTHORIZATION

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Physician's name		Certified Specialty			Physician's stamp
Street address					
City	Province	Postal code	Phone number (10 digits)	Fax number (10 digits)	
Physician's signature **X**			Date (mm-dd-yyyy)		