SASKATCHEWAN BLUE CROSS®

PO Box 4030, 516 2nd Avenue North, Saskatoon, SK S7K 3T2
Telephone 306.244.1192 Fax 306.652.5751 www.sk.bluecross.ca

OUT OF PROVINCE BENEFITS CLAIM FORM

INSTRUCTIONS:

1. Please sign and date the Declaration and Consent on the reverse side of this form.
2. **Patient's Home Physician & Home Specialist must complete the reverse side of this form. Failure to complete the form in full will result in a delay in processing the claim.**
3. Please provide documentation to support date of departure, e.g., airline ticket or accommodation receipt.
4. If there is a charge for completing this form, it is the responsibility of the individual claiming the benefit.

1. PATIENT'S SURNAME _____ PATIENT'S FIRST NAME _____

   POLICY # _____ IDENTIFICATION # _____

   STREET ADDRESS _____ CITY/TOWN _____

   POSTAL CODE _____ PHONE (_____) _____

2. PATIENT'S PROVINCIAL HEALTH # _____ BIRTH DATE _____ / _____ / _____
   YYYY MM DD

3. DESCRIBE ILLNESS OR INJURY (Including symptoms, onset of illness and diagnosis).

   _____

   _____

   _____

   _____

   _____

   _____

4. REASON FOR ABSENCE FROM PROVINCE OF RESIDENCE

   ☐ Moved ☐ Student ☐ Vacation ☐ Obtain Medical Care ☐ Business Trip ☐ Other (specify) _____

   DATES: Departure _____

   Expected Return _____

   Actual Return _____

   COUNTRY TRAVELLED _____ CURRENCY _____

5. DOES THE PATIENT CARRY, OR IS THE PATIENT COVERED UNDER ANY OTHER EXTENDED HEALTH COVERAGE WITH ANY FIRM BESIDES SASKATCHEWAN BLUE CROSS AND THE GOVERNMENT PLANS?

   YES _____ NO _____ If YES, please provide the following information:

   Name of Insurance Company _____

   Address _____

   _____ Phone No. _____

   Policy/ID # _____ Effective Date _____ Expiry Date _____

DECLARATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy, to develop and 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 include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, any Saskatchewan Health Agency including the Saskatchewan Prescription Drug Plan and Saskatchewan Health Registration, the policy holder or certificate holder of any policy under which I am a participant, and other third parties when required to administer the benefits outlined in my policy.

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 or refusing to consent to its disclosure. For additional information regarding the privacy policies of Saskatchewan Blue Cross and/or the collection, use of or disclosure of my personal information, I may visit www.sk.bluecross.ca or call 1-800-USEBLUE®.

I hereby certify that the information provided herein is correct and true to the best of my knowledge and belief and authorize Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada to collect, use and disclose my personal information or the personal information of any covered dependents as described above.

SIGNATURE OF CARDHOLDER _____ Date _____

TO BE COMPLETED BY HOME PHYSICIAN (PLEASE PRINT)

Please provide details of all visits during the 180 days prior to leaving province of residence.

DATE OF VISIT	SYMPTOMS, DIAGNOSIS	TYPE OF EACH TREATMENT & NAME OF EACH PRESCRIPTION DRUG

Name of Physician _____ Phone _____

Signature _____ Date _____

TO BE COMPLETED BY HOME SPECIALIST (PLEASE PRINT)

Please provide details of all visits during the 180 days prior to leaving province of residence.

DATE OF VISIT	SYMPTOMS, DIAGNOSIS	TYPE OF EACH TREATMENT & NAME OF EACH PRESCRIPTION DRUG

Name of Specialist _____ Phone _____

Signature _____ Date _____

MSI 108 3M 12/11