

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that I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded.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 Saskatchewan Blue Cross' privacy policies I can contact Saskatchewan Blue Cross at www.sk.blueross.ca or 1-800-USE-BLUE should I have questions as to the collection, use of or disclosure of my personal information.

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

Please indicate the date of each visit, medical problem, and type of treatment received for the 180 days immediately prior to departure date.

TO BE COMPLETED BY PHYSICIAN

DATE	ILLNESS OR CONDITION	TYPE OF TREATMENT

Date _____ Physician's Signature _____

Name and Address of Physician _____
(Please print) _____

TO BE COMPLETED BY SPECIALIST

DATE	ILLNESS OR CONDITION	TYPE OF TREATMENT

Date _____ Specialist's Signature _____

Name and Address of Specialist _____
(Please print) _____

If there is a charge for completing this form, it is the responsibility of the individual claiming the benefit.