PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

EMPLOYEE LIFE INSURANCE & ACCIDENTAL DEATH CLAIM CHECKLIST

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Phone: 604 419-2000 Toll-free: 1 877 722-2583 Fax: 604 419-8055

You can help us to review this claim quickly and accurately by providing all the information requested on the forms below:

You can help us to review this claim quickly and accurately by providing the documentation below:

- ☐ Employee Life Insurance Claim Form
- ☐ Attending Physician's Statement of Death (APS) **OR**
- ☐ Government issued Certificate of Death (death certificate)

In all cases, either the APS or the death certificate must be an original or certified copy. The copy can be certified by: the funeral home director; notary public; lawyer; or bank officer at the deceased's bank. Original death certificates will be returned.

Do not delay submitting the claim form while waiting for the APS, Coroner's report or the Death Certificate.

We reserve the right to request additional documentation as required, depending on the details of the claim.

Self-administered and third party administrators should also forward a copy of the group enrolment form.

Claims must be submitted by the claiming deadline for this policy. If you have any questions about the documents or information required, contact the Life & Disability Claims department at 604-419-2000 or toll free at 1-877-722-2583.

Mail this claim to:

Pacific Blue Cross
Life & Disability Claims
PO Box 7000
Vancouver, BC V6B 4E1

Hand deliver or courier to:

Pacific Blue Cross
Life & Disability Claims
4250 Canada Way
Burnaby, BC V5G 4W6

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EMPLOYEE LIFE INSURANCE & ACCIDENTAL DEATH CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Phone: 604 419-2000 Toll-free: 1 877 722-2583 Fax: 604 419-8055

PART 1 — EMPLOYER'S STATEMENT

Please ensure this form is fully completed before submitting it to BC Life & Casualty Company. Failure to provide all information requested could delay assessment.

Policy number	Name of group policyholder				
Division	Class	Sub-division (if applicable)			
Name of deceased					ID number
Street address	Box number (if applicable)	City	Province	Postal code	Phone number
Date of birth (mm-dd-yyyy)	Date of death (mm-dd-yyyy)	Date employed (mm-dd-yyyy)	Job title	Date date last worked (mm-dd-yyyy)	

Reason the employee stopped working (retirement, illness, leave of absence, termination etc.)

Effective date of deceased's insurance (mm-dd-yyyy)	Date premiums paid to (mm-dd-yyyy)	Basic earnings on last day worked: $	per	Amount of insurance in force at death: $

Beneficiary	Relationship to deceased
Beneficiary	Relationship to deceased
Beneficiary	Relationship to deceased

NOTE: If a beneficiary has been designated, provide the requested information above. If beneficiary predeceased the insured person, benefits under the terms of the group policy will be paid to the insured person's estate. Attach any requests for change of beneficiary which have not been submitted to the insurer.

Complete only if applying for the Accidental Death benefit

Date of accident (mm-dd-yyyy)	Did the accident occur while the deceased was engaged in company business ☐ Yes ☐ No

If yes, provide details

Effective date of deceased's AD&D insurance (mm-dd-yyyy)	Date AD&D premiums paid to (mm-dd-yyyy)
Is this a self-administered plan? ☐ Yes ☐ No	If yes, attach the original application form and any change cards.
Is this a third party administered plan? ☐ Yes ☐ No	If yes, attach a copy of the billing for the month of death, the original application card and any change cards.

Please provide any other information that will help BC Life assess this claim

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

Completed by (please print)	Phone number	Date (mm-dd-yyyy)
Signature of authorized official **X**	Title	

PART 2 — CLAIMANT'S STATEMENT

Please ensure this form is fully completed before submitting it to BC Life & Casualty Company. Failure to provide all information requested could delay assessment.

Name of deceased	Policy number	Social insurance number

In what capacity are you claiming the insurance proceeds?	☐ beneficiary ☐ executor ☐ administrator ☐ trustee for a minor child
	☐ other (specify)

Name of claimant	Social insurance number	Date of birth (mm-dd-yyyy)

Street address	Box number (if applicable)	City	Province	Postal code

Relationsip to deceased ☐ spouse ☐ brother ☐ sister ☐ child ☐ Other (specify)	Phone number

Complete only if applying for the Accidental Death benefit

Date of accident (mm-dd-yyyy)	Time of accident ☐ am ☐ pm	Where did it happen

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to British Columbia Life & Casualty Company (BC Life), all information in their possession or within their knowledge in respect to the deceased. I agree that a photocopy of this authorization shall be as valid as the original. I certify that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of claimant **X**	Date (mm-dd-yyyy)

Additional Beneficiaries

If more than one beneficiary is entitled to receive the insurance proceeds, only the claimant indicated above is required to sign the authorization, but the others must apply for the insurance proceeds by providing the infomation requested below:

Name	Date of birth (mm-dd-yyyy)

Street address	Box number (if applicable)	City	Province	Postal code

Relationsip to deceased	Social insurance number

Name	Date of birth (mm-dd-yyyy)

Street address	Box number (if applicable)	City	Province	Postal code

Relationsip to deceased	Social insurance number

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Attending Physician's Statement of Death

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-2000 Fax 604 419-8055 Toll-free: 1 877 722-2583

May be completed by coroner

Name of deceased _____

Date of birth ___ ___ ___ (Mo Day Yr) Date of death ___ ___ ___ (Mo Day Yr) Age at death _____

Place of death (if hospital or institution, give name) _____

Cause of death: Principal cause _____ Date of onset ___ ___ ___ (Mo Day Yr)

Contributory causes _____ Date of onset ___ ___ ___ (Mo Day Yr)

Death was due to: ❑ accident ❑ suicide ❑ homicide Please provide full explanation: _____

_____

_____

_____

If due to an accident, was the accident work related? ❑ Yes ❑ No

Was an inquest held? ❑ Yes ❑ No

Was an autopsy performed? ❑ Yes ❑ No

Please provide findings of inquest or autopsy: _____

_____

I attended deceased from ___ ___ ___ (Mo Day Yr) to ___ ___ ___ (Mo Day Yr)

If applicable, was the deceased unable to work due to a medical condition prior to death? ❑ Yes ❑ No

If yes, please provide date of total impairment ___ ___ ___ (Mo Day Yr) and details of condition: _____

_____

Did you treat or advise the deceased during the three years prior to this last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, receive treatment during the last three years from any other physician or in any hospital or institution? ❑ Yes ❑ No

If yes, to either of the two preceding questions, please provide the following:

Name	Address	Nature of illness or injury	Approximate dates

These statements are true and complete to the best of my knowledge and belief.

Name and specialty (please print) _____

Address (please print) _____ Phone number _____

Signature _____ MD Date ___ ___ ___ (Mo Day Yr)

The claimant is responsible for the cost of completing this form.

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