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DEPENDENT LIFE INSURANCE 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:

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

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 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.

Claims must be submitted by your policy claiming deadline. 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

0544 92-60-107 02/17 CUPE 1816

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DEPENDENT LIFE CLAIM FORM

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PART 1 — EMPLOYER'S STATEMENT

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

Policy number	Name of group policyholder				
Division	Class	Sub-division (if applicable)			
Name of employee	ID number	Job title	Date employed (mm-dd-yyyy)	Basic earnings per wk/mo/yy $	Hours per week

At the time of the dependent's death was the employee actively at work?

☐ Yes	Date last worked prior to dependent's death (mm-dd-yyyy)	☐ No	Date last worked prior to dependent's death (mm-dd-yyyy)	Reason for stopping work

Effective date of dependent insurance (mm-dd-yyyy)	Amount of insurance for deceased dependent $
Date premiums paid to for employee's insurance (mm-dd-yyyy)	Date premiums paid to for dependent insurance (mm-dd-yyyy)

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

Name of deceased dependent	Relationship to employee

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 — EMPLOYEE'S CONSENT AND DECLARATION - must be completed by employee

First name	Last name	Social insurance number	Date of birth (mm-dd-yyyy)

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

First name of deceased dependent	Last name of deceased dependent

Address of deceased dependent

Deceased dependent's date of birth (mm-dd-yyyy)	Deceased dependent's date of death (mm-dd-yyyy)	Relationship to you

Was the deceased person financially dependent upon you? ☐ Yes ☐ No

If the deceased person was not your spouse, was the deceased dependent married? ☐ Yes ☐ No

Was the deceased dependent attending school? ☐ Yes ☐ No If yes, name of school

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 and I agree that a photocopy of this authorization shall be as valid as the original. I certify that the information provided above 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 employee **X**	Date (mm-dd-yyyy)

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ATTENDING PHYSICIAN'S STATEMENT OF DEATH

May be completed by coroner

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

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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