


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)

If the claim is also for Accidental Death benefits, both an Attending Physician's Statement and Death Certificate must be provided. Either the APS or the death certificate must be an original or certified copy. All forms, including the APS and Death Certificate, can be scanned and submitted to [BCLife@pac.bluecross.ca](mailto:BCLife@pac.bluecross.ca). 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.

Email this claim to: [BCLife@pac.bluecross.ca](mailto:BCLife@pac.bluecross.ca)

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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## PART 1 — EMPLOYER'S STATEMENT

**i** 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
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 <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, attach the original application form and any change cards.	
Is this a third party administered plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>X</b>		Title	

## PART 2 — CLAIMANT'S STATEMENT

**i** 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?		<input type="checkbox"/> beneficiary <input type="checkbox"/> executor <input type="checkbox"/> administrator <input type="checkbox"/> trustee for a minor child			
		<input type="checkbox"/> other (specify)			
Name of claimant			Social insurance number	Date of birth (mm-dd-yyyy)	
Street address	Box number (if applicable)	City	Province	Postal code	
Relationship to deceased <input type="checkbox"/> spouse <input type="checkbox"/> brother <input type="checkbox"/> sister <input type="checkbox"/> child <input type="checkbox"/> Other (specify)					Phone number

### Complete only if applying for the Accidental Death benefit

Date of accident (mm-dd-yyyy)	Time of accident <input type="checkbox"/> am <input type="checkbox"/> pm	Where did it happen
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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 <b>X</b>	Date (mm-dd-yyyy)
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### 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 information requested below:

Name			Date of birth (mm-dd-yyyy)		
Street address	Box number (if applicable)	City	Province	Postal code	
Relationship to deceased			Social insurance number		
Name			Date of birth (mm-dd-yyyy)		
Street address	Box number (if applicable)	City	Province	Postal code	
Relationship to deceased			Social insurance number		

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.

