PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

LIVING BENEFIT EMPLOYER AND EMPLOYEE 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:

- ☐ Employer and Employee Living Benefit Claim Form
- ☐ Living Benefit Attending Physician's Statement
- ☐ A copy of the employee's Group Enrolment or change of Beneficiary card

If this claim is accepted, Pacific Blue Cross (Life & Disability Claims) will provide an agreement for the employee and beneficiary to complete and return. Upon receipt of the signed agreement, payment can be released.

If you have any questions about the documents or information required, contact 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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LIVING BENEFIT EMPLOYER AND EMPLOYEE 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

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

PART 1 — EMPLOYER'S STATEMENT

Name of group policyholder	Policy number	Division	Class	Sub-division (if applicable)
First name	Last name	ID number	Date employed (mm-dd-yyyy)	Job title
Date last worked (mm-dd-yyyy)	Why did your employee stop working?			
Regular number of hours worked (per week)	Salary paid up to and including (mm-dd-yyyy)		Monthly basic earnings on last day worked $	
Has the employment been terminated? ☐ Yes ☐ No	If yes, provide date terminated (mm-dd-yyyy)	Reason for termination		
Effective date of employee's life insurance (mm-dd-yyyy)	Date insurance terminated – if applicable (mm-dd-yyyy)	Amount of life insurance coverage $		

PART 2 — EMPLOYER'S CONSENT AND DECLARATION

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

Employer's name	Date (mm-dd-yyyy)
Employer's signature X	Title

PART 3 — EMPLOYEE'S STATEMENT

IMPORTANT: Please have the Attending Physician's Statement completed.

First name	Last name	Date of birth (mm-dd-yyyy)	Sex ☐ M ☐ F	Daytime phone number (10 digits)
Street address	City	Province	Postal code	Last day worked (mm-dd-yyyy)

PART 4 — EMPLOYEE CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your claim. If legal representative, provide copy of Power of Attorney.

I, the undersigned, hereby make claim for a Living Benefit. I authorize all physicians and other persons who have attended me 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 myself. 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.

I acknowledge that interest will be charged on the amount of Living Benefit issued by BC Life, and that this interest will be Prime (or the prime lending rate) plus 2%.

Employee or legal representative signature X	Date (mm-dd-yyyy)

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LIVING BENEFIT ATTENDING PHYSICIAN'S STATEMENT

Please assist your patient by providing all details relevant to his/her condition.

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

Patient's surname	Patient's first name	Date of birth (mm/dd/yyyy)

Your above named patient has requested an advance partial payment of his/her Life Insurance benefits due to a terminal illness. To consider this request we require the following information:

Diagnosis

Prognosis

Life Expectancy

Please provide a description of your patient's medical condition, including any complications and treatment in the space provided below. Attach a copy of any recent test results.

Do you believe your patient is competent to endorse cheques and direct use of the proceeds? ☐ Yes ☐ No

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

Name of physician (print)	Specialty
Address	Telephone (ten digits)
Signature	Date (mm/dd/yyyy)

The claimant is responsible for the cost of completing this form

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