PACIFIC BLUE CROSS®

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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)

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 wwforms@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: wwforms@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

0544.008—92-60-126 12/24 CUPE 1816

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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 — PLAN SPONSOR STATEMENT

Please ensure this form is fully completed before submitting it to Pacific Blue Cross. 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 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 of death: $

Number of hours worked per week

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 Pacific Blue Cross 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 Pacific Blue Cross. Failure to provide all information requested could delay assessment.

Name of deceased	Cause of death	Policy number
In what capacity are you claiming the insurance proceeds?	☐ beneficiary ☐ executor ☐ administrator ☐ trustee for a minor child	
	☐ other (specify)	

Name of claimant	Date of birth (mm-dd-yyyy)

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

Relationship 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	Description of accident

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

Email Communication

I authorize PBC to send email communication and attachments to the above provided email address: ☐ Yes ☐ No

If yes, I agree to the following method of communication:
☐ With encryption and password protection
☐ Without encryption or password protection

I understand that email communication and attachments may include confidential and personal information such as medical and financial information involving my claim.

PART 3 — CLAIMANT'S SIGNATURE

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 Pacific Blue Cross, 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 Pacific Blue Cross in effect from time to time.

Signature of claimant **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 _____ (mm-dd-yyyy) Date of death _____ (mm-dd-yyyy) Age at death _____

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

Cause of death: Principal cause _____ Date of onset _____ (mm-dd-yyyy)

Contributory causes _____ Date of onset _____ (mm-dd-yyyy)

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 _____ (mm-dd-yyyy) to _____ (mm-dd-yyyy)

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 _____ (mm-dd-yyyy) 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 _____ (mm-dd-yyyy)

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

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