British Columbia Life & Casualty Company

Accidental Loss/Dismemberment
Individual Plan Claim Checklist

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

Help us to process your claim quickly and accurately. Ensure that the following forms are completed and that the originals of these forms are submitted:

- ☐ Accidental Loss/Dismemberment Individual Plan Claim form
- ☐ Accidental Loss/Dismemberment Attending Physician's Statement

Your claim for this benefit must be submitted to BC Life by your policy claiming deadline. If you have any questions about your claim or about these forms, please contact our BC Life Claims Department at 604 419-8040.

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1

92-60-113 05/04 CUPE 1816

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Accidental Loss/Dismemberment
Individual Plan Claim Form

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Policyholder Information

Name of policyholder _____ Policy number _____ Social insurance number _____

Date of birth ___ ___ ___ (Mo Day Yr) Effective date of insurance ___ ___ ___ (Mo Day Yr) Amount of insurance you are claiming: $ _____

Address _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____ Phone number _____

If the injured person is a dependent, please answer the following questions:

Relationship to injured person _____

Is the injured person financially dependent upon you? ❑ Yes ❑ No

If the injured person is not your spouse, is the injured dependent married? ❑ Yes ❑ No

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I hereby certify that the answers on this form are true and complete to the best of my knowledge and belief.

Signature of policyholder _____ Date ___ ___ ___ (Mo Day Yr)

Signature of witness _____ Date ___ ___ ___ (Mo Day Yr)

Accident Information

Name of injured person _____ Date of birth ___ ___ ___ (Mo Day Yr)

Address _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____ Phone number _____

Date of accident ___ ___ ___ (Mo Day Yr) Time of accident _____ ❑ A.M. ❑ P.M. Where did the accident occur? _____

Describe how the accident happened. _____

_____

What injuries were caused by the accident? _____

_____

Were there any witnesses to the accident? ❑ Yes ❑ No If yes, provide names and addresses: _____

_____

Were you hospitalized as a result of the accident? ❑ Yes ❑ No If yes, where and when: _____

_____

Provide information regarding physicians seen for this injury:

Name	Address	Date first seen	Reason
_____	_____	___ ___ ___ (Mo Day Yr)	_____
_____	_____	___ ___ ___ (Mo Day Yr)	_____
_____	_____	___ ___ ___ (Mo Day Yr)	_____

I authorize the release of all reports and medical information which may be needed to assess my claim for accidental loss/dismemberment benefits to British Columbia Life & Casualty Company (BC Life). A photocopy of this authorization is as valid as the original. I hereby certify that the answers on this form are 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 patient _____ Date ___ ___ ___ (Mo Day Yr)

If the patient is a minor, a legal guardian may sign this authorization on their behalf.

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Accidental Loss/Dismemberment
Attending Physician's Statement

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Name of patient _____

Date of birth Mo Day Yr Date of injury Mo Day Yr Date of first visit for injury Mo Day Yr

Describe the injury. _____

_____

Provide name and address of hospital where treated: _____

_____

Dates hospitalized Mo Day Yr to Mo Day Yr Mo Day Yr to Mo Day Yr

Was the injury work related? ❑ Yes ❑ No

Was the injury described solely responsible for the loss? ❑ Yes ❑ No

If no, provide details of other causes and names of other physicians consulted: _____

_____

_____

Loss of Limbs/Loss of Finger, Thumb or Toe. Indicate each loss separately and at which joint the severance occurred (**above** means towards the body and **below** means away from the body):

1. _____ Date of loss Mo Day Yr
2. _____ Date of loss Mo Day Yr
3. _____ Date of loss Mo Day Yr

Loss of Sight

The accident resulted in total and irrecoverable loss of sight: ❑ Yes ❑ No

❑ Left eye Date of loss Mo Day Yr ❑ Right eye Date of loss Mo Day Yr

Loss of Hearing

The accident resulted in total and irrecoverable loss of hearing: in both ears: ❑ Yes ❑ No Date of loss Mo Day Yr

in one ear: ❑ Yes ❑ No ❑ Right ❑ Left Date of loss Mo Day Yr

Loss of Speech

The accident resulted in total and irrecoverable loss of speech: ❑ Yes ❑ No Date of loss Mo Day Yr

I certify that the above answers 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.