PACIFIC BLUE CROSS®

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ACCIDENTAL DEATH INDIVIDUAL PLAN 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:

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 Death Individual Plan Claim form
- ☐ Attending Physician's Statement of Death (APS) **OR**
- ☐ Government issued Certificate of Death (death certificate)

One of these must be an original

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

Email this claim to: 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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ACCIDENTAL DEATH INDIVIDUAL PLAN CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

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 _____

Accident Information

Name of deceased _____

Address _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____

Date of birth ___ ___ ___ (Mo Day Yr) Date of death ___ ___ ___ (Mo Day Yr)

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

Describe how the accident happened: _____

_____

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

_____

Was the deceased hospitalized as a result of the accident? ❑ Yes ❑ No If yes, where and when? _____

Names and addresses of all physicians who attended the deceased in the past 5 years (if insufficient space, please attach a separate sheet)

Name	Address	Date (Mo Day Yr)	Reason

Claimant Information

In what capacity do you claim the insurance proceeds? (e.g. named beneficiary, executor, policyholder or other) _____

Name of claimant _____ Social insurance number _____ Date of birth ___ ___ ___ (Mo Day Yr)

Address _____ Box number (if applicable) _____

City _____ Province _____ Postal code _____ Phone number _____

Relationship to deceased _____

If the deceased was a dependent, please answer the following questions:

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

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. I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions, and government authorities to release to Pacific Blue Cross, all information requested for this claim. A photocopy of this authorization is as valid as the original. 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 _____ Date ___ ___ ___ (Mo Day Yr)

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

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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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