BLUE CROSS

GROUP DEATH CLAIM FORM

LIFE INSURANCE COMPANY OF CANADA
P. O. Box 1046, Winnipeg, MB R3C 2X7
Tel: (204) 775-0161 Fax: (204) 772-5655

EMPLOYER'S STATEMENT

EMPLOYEE NAME	GROUP NUMBER	CONTRACT NUMBER
NAME OF DECEASED	DATE OF BIRTH ___ DAY ___ MONTH ___ YEAR	DATE OF DEATH ___ DAY ___ MONTH ___ YEAR
LAST ADDRESS OF DECEASED		
IF DECEASED IS OTHER THAN EMPLOYEE, WHAT IS THE RELATIONSHIP TO THE EMPLOYEE?		
IF THE DECEASED IS THE EMPLOYEE DATE EMPLOYED ___ DAY ___ MONTH ___ YEAR	LAST DATE WORKED ___ DAY ___ MONTH ___ YEAR	ANNUAL SALARY AT TIME OF DEATH $_____ OCCUPATION_____

BENEFIT CLAIMED

LIFE INSURANCE $_____ OPTIONAL LIFE INSURANCE $_____

ACCIDENTAL DEATH $_____ DEPENDANT LIFE INSURANCE $_____

OTHER $_____

SIGNATURE OF AUTHORIZED PERSON _____ DATE_____

CLAIMANT'S STATEMENT

CAUSE OF DEATH	PAYMENT REQUESTED IN ☐ ONE SUM ☐ OTHER (DESCRIBE BELOW)
NAME OF CLAIMANT(S) _____ _____	CLAIMANT'S SOCIAL INSURANCE NUMBER(S) (Required for income tax purposes when interest amount exceeds $100.00) _____ _____
IN WHAT CAPACITY ARE YOU CLAIMING BENEFITS ☐ BENEFICIARY ☐ EXCECUTOR ☐ TRUSTEE ☐ ADMINISTRATOR	CLAIMANT'S AGE (If over legal age state "Over Legal Age"

COMPLETE IF DEATH WAS RESULT OF ACCIDENT

PLACE OF ACCIDENT	DATE OF ACCIDENT ___ DAY ___ MONTH ___ YEAR	
DESCRIPTION OF ACCIDENT?	WAS INQUEST HELD	☐ YES ☐ NO
	WAS AUTOPSY PERFORMED	☐ YES ☐ NO

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of the group policy of the late _____, and to manage the Company's business.

Depending on the type of coverage carried, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the policy holder or certificate holder of any policy under which the deceased was a participant, and other third parties when required to administer the benefits outlined in the policy.

I understand the personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why the personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 204-775-0161 and our website at www.mb.bluecross.ca should I have questions as to the collection, use of or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose the personal information as described above.

Dated at _____ the _____ day of _____, 20_____

_____ Signature of Claimant

_____ Address

_____ Signature of Witness

_____ Address