MEDAVIE BLUE CROSS™

DEATH CLAIM FORM

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TELEPHONE: 1-800-355-9133 FAX: (416) 626-0400

Instructions - This form should be completed and returned to Medavie Blue Cross, together with the "Proof of Death Physician's Statement" and evidence of age.

STATEMENT OF EMPLOYER

Policyholder | Policy No. | Identification No.

Name of Deceased | Date of Birth | Date of Death | Social Insurance No.

Last Address of Deceased

If Dependent Claim, Name of Insured Employee | Relationship to Insured Employee

EMPLOYEE INFORMATION

Date Employed | Last Full Day Worked | Annual Salary At Time of Death | Occupation at Time of Death

Benefits Being Claimed

Life Insurance $ | Optional $ | Accidental Death $ | Dependent Life $

Dated at _____ Policyholder _____

this _____ day of _____ year _____ per _____

Signature _____ Title _____

STATEMENT OF CLAIMANT

Name of Deceased | Identification No. of Deceased | Policy No. of Deceased

Cause of Death | Payment Requested ☐ One Sum ☐ Other (please describe below)

Name of Claimant

Relationship (beneficiary, trustee, executor, etc.) | Age of Claimant (if over legal age, state "over legal age") | Social Insurance No. - Beneficiary

COMPLETE IF DEATH WAS RESULT OF AN ACCIDENT

Place of Accident | Date of Accident

Description of Accident

CERTIFICATION

I hereby certify that the above information is correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ year _____

Signature of Claimant | Address

Signature of Witness | Address

FORM-190(B) 07/05

MEDAVIE BLUE CROSS™

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of the late _____ or his/her health to give to Medavie Blue Cross any such information. A photocopy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ year _____

Signature of Claimant _____ Address _____

Signature of Witness _____ Address _____