Procedure for Processing Insurance Death Claims

PURPOSE

The purpose of this document is to outline the procedure for processing death claim with Medavie Blue Cross.

SCOPE

This procedure applies to all Canadian Sofina locations.

FREQUENCY & TIMING

When a plan member or dependent passes away a Death Claim needs to be processed with Medavie Blue Cross in order to arrange for payment of the insurance proceeds.

PROCEDURE

1. When an employee passes away a member of the local Human Resources team should reach out to the employee's family or beneficiary to express Sofina's sympathies and initiate the death claim process. Depending on the situation, the HR representative may support the beneficiary directly with this process or refer them to deal with Medavie Blue Cross instead.

2. Payroll should complete the first two sections (Statement of Employer and Employee Information) on the Death Claim Form to provide to the local HR representative. *(Refer to Appendix: 1. Death Claim Form.)*

3. HR should provide the beneficiary with the semi-completed form, review the Medavie Blue Cross submission process with them and answer any questions. If the HR representative has death claim processing questions they should call Medavie Blue Cross at the 1-800 number provided on the form.

4. In addition to the Death Claim form, a copy of the enrolment form or beneficiary designation form and proof of death is required. For claims up to $100,000 a funeral director's certification is sufficient. Claims over $100,000 require the Medavie Blue Cross Proof of Death form to be completed. (*Refer to Appendix: 2. Proof of Death Form)*

SECTION: Human Resources	**EFFECTIVE DATE: January 27, 2015**
APPLICABLE TO: Canada	**REVISION DATE:**
RELATED PROCEDURES:	**PAGE: 1 of 4**
APPROVALS: Senior Manager, Total Rewards	**PROCEDURE NUMBER**: TR - 02

5. The beneficiary may either submit their claim documentation directly to Medavie Blue Cross to the address indicated on the form, or to their HR representative for them to submit the claim on their behalf.

6. Medavie Blue Cross will adjudicate the claim and pay the proceeds of the insurance coverage directly to the beneficiary. In special circumstances where the HR representative would like to receive the cheque on behalf of the beneficiary they can make arrangements for this through Medavie Blue Cross.

RELATED PROCEUDRE

1. For employees who were also member of the Employee Pension Plan or Group RRSP plan please refer to the Procedure for Processing Retirement Death Claims *(Note: retirement death claim procedure to be created)*.

APPENDIX:

1. Death Claim Form

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 _____ this _____ day of _____ year _____

Signature _____

Policyholder _____

per _____

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 _____

2. Proof of Death

MEDAVIE BLUE CROSS™

PROOF OF DEATH
PHYSICIAN'S STATEMENT

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

If there is a charge for completing this form, it is the responsibility of the individual claiming benefit.

Full name of deceased _____ Residence at death _____ Age at death _____ **OR** Date of birth (DD / MM / YY) _____	Date of death _____ Place of death (if Hospital or Institution, give name) _____ _____

Cause of Death *(Enter only one cause for each of a, b and c.)*	Interval between onset and death
Disease or condition directly leading to death: *(This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication that caused death.)* (a)	(a)
Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.)*	
Due to or as a consequence of (b)	(b)
Due to or as a consequence of (c)	(c)
Other significant conditions: *(Contributing to the death but not related to the disease or condition causing death.)*	

Date of first attendance in last illness (DD / MM / YY)	Date of last attendance in last illness (DD / MM / YY)
If death was due to accident, homicide or suicide, specify which. Describe briefly.	Was an inquest held? ❑ Yes ❑ No Was an autopsy performed? ❑ Yes ❑ No If so, by whom and with what findings?

Have you treated or advised the deceased during the last 3 years, prior to last illness? ❑ Yes ❑ No

Did the deceased, to your knowledge, smoke any tobacco or used any tobacco or nicotine in any form (including nicotine replacement products) during the last 3 years? ❑ Yes ❑ No

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? ❑ Yes ❑ No

If Yes to either question, please furnish the following:

Name	Address	Nature of Illness or Injury	Dates (DD / MM / YY)

Physician's Full Name (Please Print) _____

Physician's Signature _____ Date _____

Address _____

The medical certification follows the recommendations of the World Health Assembly, made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

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