ALBERTA BLUE CROSS®

GROUP DEATH CLAIM FORM

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 587-756-8631 or 1-800-763-6206
Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

Submit this form directly to Alberta Blue Cross, Life & Disability Services (see contact information above).

Employer statement

Group/policy name	Group/policy number	Section	ID number

Name of deceased	Birth date (YYYY-MM-DD)	Date of death (YYYY-MM-DD)

Last address of deceased

Employee information

Date employed (YYYY-MM-DD)	Last day worked (YYYY-MM-DD)	Annual salary at time of death	Occupation at time of death
		$	

Benefits being claimed

Life insurance	Optional	Accidental Death	Dependent Life
$	$	$	$

I hereby declare that the answers to the above questions are accurate and complete

Name	Position or title

Phone	Fax	Email

Signature	Date (YYYY-MM-DD)

Claimant's statement

Name of claimant	Relationship (beneficiary, trustee, executor, etc.)	Age of claimant	Social insurance number (claimant)

Cause of death

Payment requested ☐ One sum ☐ Other (please describe below)

Complete if death was a result of an accident

Place of accident	Date of accident (YYYY-MM-DD)

Description of accident

Acknowledgment and consent

I authorize Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its agents to collect, use, maintain and disclose personal information for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claim management. I acknowledge and agree that my personal information may only be collected from and/or released to a third party (health care professional/practitioner/insurer or reinsurer/agent of record) only when needed for a purpose stated above. Medical and health information excludes genetic test results. I confirm that I am authorized by my spouse and dependants to receive and disclose information about them that is used solely for these purposes.

I understand that I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.

I understand why I have been asked to disclose this information and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

I agree that this consent shall be effective on the date of this application and shall be valid for the duration of the time coverage is in force.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please visit our web site at ab.bluecross.ca or email our privacy compliance officer at privacy@ab.bluecross.ca.

Claimant name (please print)	Signature of claimant	Date (YYYY-MM-DD)

Address of claimant	Phone	Email

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.