British Columbia Life & Casualty Company

Employee Life Insurance & Accidental Death
Claim Checklist

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

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. Submit the Employer's Statement and the Claimant's Statement as soon as they are completed. Do not delay the submission of these forms while waiting for the Attending Physician's Statement of Death or Coroner's report.

- ☐ Employee Life Insurance & Accidental Death Claim Form
- ☐ Attending Physician's Statement of Death
- ☐ Government issued Certificate of Death

} One of these must be an original

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

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1

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British Columbia Life & Casualty Company

Employee Life Insurance & Accidental Death
Claim Form

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Telephone 604 419-8040 Fax 604 419-8055

Employer's Statement

Name of group policyholder ______________________________ Policy number ______________

Name of deceased ______________________________ Social insurance number ______________________________

Address of deceased ______________________________ Box number (if applicable) ______________

City ______________________________ Province ____________ Postal code ______________

Date of birth [Mo | Day | Yr] Date of death [Mo | Day | Yr]

Date employed [Mo | Day | Yr] Occupation ______________________________ Date last worked [Mo | Day | Yr]

Reason the employee stopped working (retirement, illness, leave of absence, termination etc.) ______________________________

Effective date of deceased's insurance [Mo | Day | Yr] Date premiums paid to [Mo | Day | Yr]

Basic earnings on last day worked: $ ______________ per ______________ Amount of insurance in force at death: $ ______________

Beneficiary ______________________________ Relationship to deceased ______________________________

Beneficiary ______________________________ Relationship to deceased ______________________________

Beneficiary ______________________________ Relationship to deceased ______________________________

NOTE: If a beneficiary has been designated, provide the requested information above. If beneficiary predeceased the insured person, benefits under the terms of the group policy will be paid to the insured person's estate. Attach any requests for change of beneficiary which have not been submitted to the insurer.

Complete only if applying for the Accidental Death benefit

Date of accident [Mo | Day | Yr] Did the accident occur while the deceased was engaged in company business ❑ Yes ❑ No

If yes, provide details ______________________________

Effective date of deceased's AD&D insurance [Mo | Day | Yr] Date AD&D premiums paid to [Mo | Day | Yr]

Is this a self-administered plan? ❑ Yes ❑ No If yes, attach the original application form and any change cards.

Is this a third party administered plan? ❑ Yes ❑ No If yes, attach a copy of the billing for the month of death, the original application card and any change cards.

Please provide any other information that will help BC Life assess this claim ______________________________

____

I certify that the information provided above is true and complete to the best of my knowledge and belief.

Completed by (print) ______________________________ Phone number ______________ Date [Mo | Day | Yr]

Signature of authorized official ______________________________ Title ______________________________

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Please ensure this form is fully completed before submitting it to BC Life & Casualty Company. Failure to provide all information requested could delay assessment.

Claimant's Statement

Name of deceased ______________________________

Policy number ____________________ Social insurance number ____________________

In what capacity are you claiming the insurance proceeds? ❑ beneficiary ❑ executor ❑ administrator ❑ trustee for a minor child ❑ other (specify) ____________

Name of claimant ______________________________

Social insurance number ____________ Date of birth Mo Day Yr

Address of claimant ______________________________ Box number (if applicable) ________

City ____________________ Province ________ Postal code ________

Relationship to deceased ❑ spouse ❑ brother ❑ sister ❑ child ❑ Other(specify) ________

Complete only if applying for the Accidental Death benefit

Date of accident Mo Day Yr Time of accident ________ ❑ A.M. ❑ P.M.

Where did the accident happen? ______________________________

Were the police in attendance at the scene of the accident? ❑ Yes ❑ No If you have the police report, please attach a copy.

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I authorize all physicians and other persons who have attended the deceased and all hospitals, institutions and government authorities to furnish to British Columbia Life & Casualty Company (BC Life), all information in their possession or within their knowledge in respect to the deceased. I agree that a photocopy of this authorization shall be as valid as the original. I certify that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of claimant ______________________________ Date Mo Day Yr

Additional Beneficiaries

If more than one beneficiary is entitled to receive the insurance proceeds, only the claimant indicated above is required to sign the authorization, but the others must apply for the insurance proceeds by providing the infomation requested below:

Name ______________________________ Date of birth Mo Day Yr

Address ______________________________

Relationship to deceased ____________________ Social insurance number ____________________

Name ______________________________ Date of birth Mo Day Yr

Address ______________________________

Relationship to deceased ____________________ Social insurance number ____________________

British Columbia Life & Casualty Company

Attending Physician's Statement of Death

Disability & Life Claims PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Fax 604 419-8055

May be completed by coroner

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: ______________________________

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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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