ALBERTA BLUE CROSS®

GROUP LIFE 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

To apply for group life claim benefits, please review the following requirements and submit the applicable documents:

All claim types

- ☐ A group life claim form completed by the beneficiaries and employer.
- ☐ A death certificate or funeral director's statement of death.

Documents required if the following scenarios apply:

- ☐ If the benefit amount is $250,000 or more, a physician's proof of death form is required.
- ☐ If payable to the estate and the benefit amount is $25,000 or more, a probated will or grant of administration is required.
- ☐ If claim is payable to a minor, the nominated trustee should complete the claim form.

If claiming Accidental Death benefits:

- ☐ all hospital records and chart notes related to the accident from time of accident up until time of death, and
- ☐ medical examiner certificate and/or autopsy report (long form).

Additional documents may be requested such as toxicology, police reports or any other documents that support the cause of death.

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

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)

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Claimant's statement

Name of claimant	Relationship (beneficiary, trustee, executor, etc.)	Birth date of claimant (YYYY-MM-DD)	Date of accident (YYYY-MM-DD)

Cause of death

- ☐ Illness
- ☐ Accident (please include details in description box below)
- ☐ Other (please include details in description box below)

Please select all that apply:

- ☐ Alzheimer's disease
- ☐ Aneurysm
- ☐ Appendicitis
- ☐ Cancer
  Specify: _____
- ☐ Chronic liver disease and cirrhosis
- ☐ Chronic rheumatic heart disease
- ☐ Complications of pregnancy or childbirth
- ☐ Congenital anomalies
- ☐ COVID-19
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ Drowning
- ☐ Drug overdose
- ☐ HIV/AIDS
- ☐ Heart attack
- ☐ Infections of kidney
- ☐ Influenza
- ☐ Leukemia
- ☐ Miscellaneous causes
- ☐ Multiple Sclerosis
- ☐ Myeloplastic syndrome
- ☐ Parkinson's disease
- ☐ Pneumonia
- ☐ Poisoning
- ☐ Pulmonary embolism
- ☐ Renal failure
- ☐ Sepsis or septicemia
- ☐ Stroke
- ☐ Undetermined or other
  Specify: _____

Payment requested ○ One sum ○ Other (please describe)

Additional details of accident or cause of death

Place of accident, if applicable	Date of accident (YYYY-MM-DD)

Additional details of accident or cause of death

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 (home)	Phone (cell)	Best time to call	Email
		○ AM ○ PM ○ Anytime	