MANITOBA BLUE CROSS®

Case Management Services

GROUP LIFE BENEFIT CLAIM FORM

NOTICE

If the proceeds of the group life benefit are being claimed by more than one person, each claimant is responsible for submitting a complete claim form.

We accept submission by

Email LDinfo@mb.bluecross.ca
Fax 204.788.5591
Mail PO Box 1046 Stn Main, Winnipeg MB R3C 2X7
In Person/Drop Box 599 Empress Street, Winnipeg Manitoba

PART 1 EMPLOYER'S STATEMENT

PART 1 to be completed by the employer's authorized plan administrator (group policyholder)

Group Policy Name	Policy Number	Certificate Number

Deceased's Name (last name, first name)	Deceased's Date of Birth (yyyy-mm-dd)

Is the Deceased? ❑ the Member/Employee ❑ a Spouse ❑ a Dependent	Date of Death (yyyy-mm-dd)

EMPLOYEE INFORMATION

Employee's Name (if different from deceased)

First Date of Employment (yyyy-mm-dd)	Last Job Title	Last Date Worked (yyyy-mm-dd)	Annual salary, at time of death
			$ /year

BENEFITS CLAIMED

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

I declare the answers to the questions above are true and complete

Name of Authorized Person (print) _____ Job Title _____ Phone (including area code) _____

Signature of Authorized Person _____ Date (yyyy-mm-dd) _____

PART 2 CLAIMANT'S STATEMENT

I am claiming benefits as (check one)

❑ Named Beneficiary ❑ Beneficiary's Guardian ❑ Estate Executor/Administrator ❑ Trustee

Claimant's Name (last name, first name)	Claimant's Date of Birth (yyyy-mm-dd)

Claimant's Mailing Address (street, city, province, postal code)
*required to issue benefit

Should we have questions, what is your preferred method of contact?

❑ phone (include area code) _____ ❑ email address _____

Cause of Death *required to issue benefit

❑ Illness Description _____

❑ Natural causes Description _____

❑ Accidental Description _____

Was inquest held? ❑ No ❑ Yes (provide medical examiner/ coroner report)	Was autopsy performed? ❑ No ❑ Yes (provide report)	Police Investigation? ❑ No ❑ Yes (provide report)

If cause of death was ACCIDENTAL, please provide the following information along with the Physician's Statement (please contact us for a copy)

Place of accident _____ Date of accident (yyyy-mm-dd) _____

Description of accident _____

I have read and understand the attached Authorization and Consent.
I understand it is an offense to make a false or misleading statement in a claim for benefits and declare the answers to the questions above are true and complete.
I understand it is my responsibility to submit a complete claim, and that I am responsible for any fees related to the completion.
I understand that Manitoba Blue Cross requires all documentation before my claim will be adjudicated. Missing information can result in delayed adjudication or denial of my claim.
I understand this Declaration is valid for the duration of my claim.

I have read the above and agree

Signature of Claimant _____ Date (yyyy-mm-dd) _____

AUTHORIZATION AND CONSENT

I understand that the personal information and personal health information provided herein as well as any other personal information and personal health information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada (collectively referred to as “Blue Cross”) may be collected, used, or disclosed to administer the terms of the policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the company’s business.

Depending on the type of coverage I carry, limited personal information or personal health information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the policy of which I am an eligible member. I understand that Blue Cross may retain service providers inside and outside of Canada to assist them in their business and further understand that my personal information may be subject to disclosure to law enforcement and other authorities, where required by law, both inside and outside of Canada, when such information is in the possession of Blue Cross or one of its authorized service providers.

I understand that I have provided my consent for Blue Cross to collect, use and disclose my personal information as outlined in the Blue Cross Privacy Code. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information and personal health information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross’s privacy policies as to the collection, use, or disclosure of my information, I may contact Blue Cross at 204.775.0151 or 1.800.873.2583 or mb.bluecross.ca.

I authorize Blue Cross to collect, use and disclose my personal information and personal health information as described above.

A photostatic copy of this authorization shall be as valid as the original.