SASKATCHEWAN BLUE CROSS®

PO Box 4030, 516 2nd Avenue North, Saskatoon, SK S7K 3T2
Telephone 306.244.1192 Fax 306.652.5751 www.sk.bluecross.ca

DEATH CLAIM FORM

Instructions: Complete and return to Saskatchewan Blue Cross along with the *Proof of Death Physician's Statement* and evidence of age.

STATEMENT OF EMPLOYER

Policyholder | Policy No. | I.D. 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 | Policyholder

this ____ day of ____ 20 ____ | per

Signature | Title

STATEMENT OF CLAIMANT

Name of Deceased | I.D. 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.) | Social Insurance No. - Beneficiary

COMPLETE IF DEATH WAS RESULT OF ACCIDENT

Place of Accident | Date of Accident

Description of Accident

CERTIFICATION AND AUTHORIZATION

I hereby certify that the above information is correct to the best of my knowledge and belief. I understand that the personal information provided herein, as well as any other personal information currently held, or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of the policy of the late

_____ and to manage the Company's business.

Depending on the type of coverage carried, limited personal 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, any Saskatchewan Health Agency including the Saskatchewan Prescription Drug Plan, the policy holder or certificate holder of any policy under which the deceased was a participant, and other third parties when required to administer the benefits outlined in the policy.

I understand the personal information will be kept confidential and secure. 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that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded.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 the personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policy of Saskatchewan Blue Cross, I can visit www.sk.bluecross.ca or contact Saskatchewan Blue Cross at 1-800-USEBLUE® with questions relating to the collection, use of or disclosure of my personal information.

I authorize Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada to collect, use and disclose the personal information as described above.

Dated at _____ this _____ day of _____ 20 ____

Signature of Claimant | Address

Signature of Witness | Address

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