MEDAVIE BLUE CROSS™

INDIVIDUAL LIFE CLAIM FORM

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-877-849-8509
FAX: 1-800-644-1722

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-877-849-8509
FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-877-849-8509
FAX: 416-626-0400

PO BOX 668 STATION B
MONTREAL QC H3B 3K3
TEL: 1-877-849-8509
FAX: 1-800-644-1722
life_claims@medavie.bluecross.ca

Instructions - This form should be completed and returned to Medavie Blue Cross with a Death Certificate.

STATEMENT OF CLAIMANT

Name of Deceased _____ Identification No. of Deceased _____ Policy No. of Deceased _____

Cause of Death _____

Claimant's Name _____ Claimant's Telephone Number _____

Relationship (beneficiary, trustee, executor, etc.) _____ Claimant's Date of Birth _____ Claimant's Social Insurance Number _____

COMPLETE IF DEATH WAS RESULT OF AN ACCIDENT

Place of Accident _____ Date of Accident _____

Description of Accident _____

CERTIFICATION

I hereby certify that the above information is correct to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ year _____

Signature of Claimant _____

Full Mailing Address _____

Signature of Witness _____

Full Mailing Address _____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person that has any records or knowledge of the late _____ or his/her health to give to Medavie Blue Cross any such information. A photocopy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ year _____

Signature of Claimant _____ Address _____

Signature of Witness _____ Address _____

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