New Nouveau Brunswick

MEDAVIE BLUE CROSS™

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-877-849-8509 FAX: 1-800-644-1722
life_claims@medavie.bluecross.ca

GROUP LIFE CLAIM FORM

Instructions - This form should be completed and returned to Medavie Blue Cross with a Death Certificate. Insured Employee Information Section must be completed.

INSURED EMPLOYEE INFORMATION

Employee Last Name: _____ Employee First Name: _____

Were premiums paid to date: ❑ Yes ❑ No

Date Employed (DD/MM/YYYY): _____ Last Full Day Worked on Site (DD/MM/YYYY): _____

GENERAL INFORMATION

Policyholder: **PROVINCE OF NEW BRUNSWICK** Policy Number: **19800-000**

Name of Deceased: _____

Date of Birth (DD/MM/YYYY): _____ Date of Death (DD/MM/YYYY): _____

Last Address of Deceased: _____

City: _____ Province: _____ Postal Code: _____

Relationship to Insured Employee: ❑ Spouse ❑ Dependent Child (attach copy of birth certificate)

STATEMENT OF CLAIMANT

Cause of Death: _____

Claimant's Name: _____ Claimant's Telephone Number: _____

Relationship (beneficiary, trustee, executor, etc.): _____

Claimant's Date of Birth (DD/MM/YYYY): _____ Claimant's Social Insurance Number: _____

Comments: _____

_____

_____

_____

_____

FORM-1011E 04/19

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DIRECT DEPOSIT AUTHORIZATION

ATTACH SAMPLE CHEQUE MARKED "VOID" HERE

Name of Bank: _____

Bank Address: _____

Financial Institution Number: _____ Branch Number: _____

Account Number: _____

I request my benefits be paid through electronic funds transfer (direct deposit) into this account. I may cancel this authorization at any time by giving written notice to Blue Cross.

Signature: _____ Date (yyyy/mm/dd): _____

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: _____

CLAIMANT'S AUTHORIZATION

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: _____

Signature of Witness: _____