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

CLAIM FOR DEATH BENEFITS
(Employee and/or Dependent)

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: ____________________

GENERAL INFORMATION

Policyholder: **PROVINCE OF NEW BRUNSWICK** Policy Number: **19800/19500**

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): ____________________

Comments: ____________________

COMPLETE IF DEATH WAS RESULT OF AN ACCIDENT

Please provide proof of death Physician's Statement as well as police report, autopsy report and toxicology report if applicable.

Place of Accident: ____________________ Date of Accident (DD/MM/YYYY): ____________________

Description of Accident: ____________________

MEDAVIE BLUE CROSS™

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CLAIM FOR DEATH BENEFITS (Employee and/or Dependent)

New Nouveau Brunswick

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: ______________________________

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