

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_