SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

GROUP LIFE CLAIM FORM

STATEMENT OF EMPLOYER

Group Name

Claimant's Name	Policy Number	Identification Number
Name of Deceased	Date of Birth (YYYY-MM-DD)	Date of Death (YYYY-MM-DD)
Last Address of Claimant		
If *Dependent Claim*, Relationship to Insured Employee		

Date of Hire (YYYY-MM-DD)	Last Full Day Worked (YYYY-MM-DD)	Annual Salary at Time of Death	Occupation at Time of Death
Life Insurance ($)	Optional ($)	Accidental Death ($)	Dependent Life ($)

I hereby declare that the answers to the above questions are accurate and complete.

Plan Administrator Name	Plan Administrator Title
Date (YYYY-MM-DD)	Signature

STATEMENT OF CLAIMANT

Name of Deceased	Cause of Death	City/Country where death occurred
Name of Claimant	Relationship (Beneficiary, trustee, executor, etc.)	Age of Claimant
Name of Beneficiary	Beneficiary's Email Address	Beneficiary's Phone Number

COMPLETE IF DEATH WAS ACCIDENTAL

Place of Accident	Date of Accident (YYYY-MM-DD)

Description of Accident:

ACKNOWLEDGMENT & CONSENT

I declare that the answers to the questions on this form are complete and accurate. I understand that the personal information I have provided may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation.

For the above purposes, I authorize any physician, pharmacy, health practitioner or other health care provider, hospital, clinic or other medical or medically related facility, insurer, employer (past and present), provincial workers compensation plan, medical or benefit payment plan, government or regulatory authority, or other organization, institute or person that has any records or knowledge of me or my health to give Saskatchewan Blue Cross or Blue Cross Life Insurance Company of Canada full particulars of such information, including any prior medical history relevant to this claim and benefits. I further authorize Saskatchewan Blue Cross and Blue Cross Life Insurance Company of Canada to disclose this information with each other, their reinsurers, investigative agencies or to any third party when required for a purpose stated above. Medical information may also be released to my personal physician or other medical practitioner.

I agree and am aware Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada may engage a collection agency to collect any overpayment that occurs during the course of my life and/or disability claim.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my 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 policies of Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.
A photocopy of this authorization shall be as valid as the original.

Claimant's Name (Print)	Claimant's Signature
Claimant's Address	Date Signed (YYYY-MM-DD)
Witness's Name (Print)	Witness's Signature
Witness's Address	