Help us to process your claim quickly and accurately. Ensure that the following forms are completed and that the originals of these forms are submitted:

- Accidental Loss/Dismemberment Individual Plan Claim form
- Accidental Loss/Dismemberment Attending Physician’s Statement

Your claim for this benefit must be submitted to BC Life by your policy claiming deadline. If you have any questions about your claim or about these forms, please contact our BC Life Claims Department at 604 419-8040.

Complete and mail your claim to:

British Columbia Life & Casualty Company
Disability & Life Claims
PO Box 7000
Vancouver BC V6B 4E1
Policyholder Information

Name of policyholder: ___________________________________________ Policy number: ___________________________ Social insurance number: ___________________________

Date of birth: Mo Day Yr Effective date of insurance: Mo Day Yr Amount of insurance you are claiming: $ ________________

Address: ___________________________________________ Box number (if applicable): ________________

City: ___________________________________ Province: _______ Postal code: ___________________ Phone number: ________________________

If the injured person is a dependent, please answer the following questions:

Relationship to injured person: ___________________________

Is the injured person financially dependent upon you? ☐ Yes ☐ No

If the injured person is not your spouse, is the injured person married? ☐ Yes ☐ No

I, the undersigned, hereby make claim for the above mentioned insurance proceeds. I hereby certify that the answers on this form are true and complete to the best of my knowledge and belief.

Signature of policyholder: ___________________________________________ Date: Mo Day Yr

Signature of witness: ___________________________________________ Date: Mo Day Yr

Accident Information

Name of injured person: ___________________________________________ Date of birth: Mo Day Yr

Address: ___________________________________________ Box number (if applicable): ________________

City: ___________________________________ Province: _______ Postal code: ___________________ Phone number: ________________________

Date of accident: Mo Day Yr Time of accident: ☐ A.M. ☐ P.M. Where did the accident occur? ___________________________

Describe how the accident happened. ___________________________________________

What injuries were caused by the accident? ___________________________________________

Were there any witnesses to the accident? ☐ Yes ☐ No If yes, provide names and addresses: ___________________________________________

Were you hospitalized as a result of the accident? ☐ Yes ☐ No If yes, where and when: ___________________________________________

Provide information regarding physicians seen for this injury:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Date first seen</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td>___________________________</td>
<td>Mo Day Yr</td>
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</tbody>
</table>

I authorize the release of all reports and medical information which may be needed to assess my claim for accidental loss/dismemberment benefits to British Columbia Life & Casualty Company (BC Life). A photocopy of this authorization is as valid as the original. I hereby certify that the answers on this form are true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

Signature of policyholder: ___________________________________________ Date: Mo Day Yr

If the patient is a minor, a legal guardian may sign this authorization on their behalf.

If the patient is a minor, a legal guardian may sign this authorization on their behalf.

Signature of witness: ___________________________________________ Date: Mo Day Yr

Date of birth: Mo Day Yr Effective date of insurance: Mo Day Yr Amount of insurance you are claiming: $ ________________
Name of patient ________________________________________________________________________________________________________

Date of birth [ ] [ ] [ ]  Date of injury [ ] [ ] [ ]  Date of first visit for injury [ ] [ ] [ ]

Describe the injury. _____________________________________________________________________________________________________

Provide name and address of hospital where treated: __________________________________________________________________________

Dates hospitalized [ ] [ ] [ ] to [ ] [ ] [ ]  [ ] [ ] [ ] to [ ] [ ] [ ]

Was the injury work related?  [ ] Yes  [ ] No

Was the injury described solely responsible for the loss?  [ ] Yes  [ ] No

If no, provide details of other causes and names of other physicians consulted: ________________________________________________ ______

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Loss of Limbs/Loss of Finger, Thumb or Toe. Indicate each loss separately and at which joint the severance occurred (above means towards the body and below means away from the body):

1. ___________________________________________________________________________ Date of loss [ ] [ ] [ ]

2. ___________________________________________________________________________ Date of loss [ ] [ ] [ ]

3. ___________________________________________________________________________ Date of loss [ ] [ ] [ ]

Loss of Sight

The accident resulted in total and irrecoverable loss of sight:  [ ] Yes  [ ] No

[ ] Left eye  Date of loss [ ] [ ] [ ]  [ ] Right eye  Date of loss [ ] [ ] [ ]

Loss of Hearing

The accident resulted in total and irrecoverable loss of hearing:  in both ears:  [ ] Yes  [ ] No  Date of loss [ ] [ ] [ ]

in one ear:  [ ] Yes  [ ] No  [ ] Right  [ ] Left  Date of loss [ ] [ ] [ ]

Loss of Speech

The accident resulted in total and irrecoverable loss of speech:  [ ] Yes  [ ] No  Date of loss [ ] [ ] [ ]

I certify that the above answers are true and complete to the best of my knowledge and belief.

Name and specialty(please print) __________________________________________________________

Address (please print) ____________________________________________________________ Phone number _________________________

Signature ____________________________________________________________________ MD [ ] [ ] [ ]

The claimant is responsible for the cost of completing this form.

* BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly-owned subsidiary of Pacific Blue Cross.