Extended Health Care Claim Form

- Use this form for **all** medical expenses and services.
- Please print clearly and be sure all sections are complete to avoid delays in processing your claim.
- Attach the **original** receipt for each expense claimed and keep photocopies for your records.
- Sign this claim form and mail your claim to your insurance company

1 Information about you – *be sure to fully complete this section*

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence ☐ English ☐ French

Your last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)	Daytime phone number
			– –	– –

Your address (street number and name)	Apartment or suite	City	Province	Postal code

2 Complete this section if you or your spouse are covered under another plan

Send your claims to your own plan first. When you receive your claim statement, send a copy plus copies of your receipts to your spouse's plan to claim any unpaid amount.

Send your spouse's claims to their plan first, then send a copy of their claim statement and receipts to your plan.
Send your children's claims first to the plan of the parent whose birthday falls earlier in the year.

Is your spouse a member of another benefit plan? ☐ No ☐ Yes If yes, please provide details below.

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	Type of coverage ☐ Single ☐ Family
		– –	

Are you claiming any expenses that are **NOT** covered under your spouse's plan? ☐ No ☐ Yes If yes, please specify:	

If your spouse's benefit plan is with your insurance company, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes	Contract number	Member ID number

Spouse's signature	Date (yyyy-mm-dd)
X	– –

Are you also a member of another benefit plan? ☐ No ☐ Yes If yes, please provide details below.

Type of coverage ☐ Single ☐ Family	Are you claiming any expenses that are **NOT** covered under your other plan? ☐ No ☐ Yes If yes, please specify:	

What is your employment status under your other benefits plan? ☐ Full-time ☐ Part-time ☐ Retired	Contract number	Member ID number

3 Information about your claim

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed.

Person for whom you are making the claim		Date of birth (yyyy-mm-dd)	Relationship to you	Full-time student	Disabled	Amount claimed
Last name	First name	– –		☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name	– –		☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name	– –		☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name	– –		☐ Yes ☐ No	☐ Yes ☐ No	$
						Total claimed $

Are you attaching receipts for out-of-Canada expenses? ☐ No ☐ Yes
If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (yyyy-mm-dd)	Out-of-Canada expenses claimed
– –	$

Are any of the expenses you're claiming the result of a work injury? ☐ No ☐ Yes
If yes, did you submit your claim to the workers' compensation plan in your province, if applicable? ☐ No ☐ Yes

Are any of the expenses you're claiming the result of a motor vehicle accident? ☐ No ☐ Yes
If yes, did you submit your claim to the automobile insurance plan in your province, if applicable? ☐ No ☐ Yes

Member's signature	Date (yyyy-mm-dd)
X	– –