MEDAVIE BLUE CROSS™

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CLAIM FORM
EXTENDED HEALTH CARE BENEFITS AND HEALTH SPENDING ACCOUNT
POLICY 91340

PLEASE COMPLETE AND MAKE NECESSARY CORRECTIONS TO YOUR ADDRESS

NAME _____

ADDRESS _____

_____ POSTAL CODE _____

NAME OF PARTICIPANT	GROUP/POLICY/CONTRACT NO.	IDENTIFICATION NO.

* PLEASE FILL OUT THIS FORM AND ENCLOSE ORIGINAL COPIES OF YOUR BILLS AND RECEIPTS. **THESE DOCUMENTS WILL NOT BE RETURNED. DUPLICATES SHOULD BE RETAINED FOR YOUR FILE.**

* PLEASE SUBMIT YOUR CLAIM WITHIN 12 MONTHS OF THE DATE ON WHICH THE EXPENSES HAVE BEEN INCURRED (UNLESS OTHERWISE STIPULATED IN YOUR CONTRACT).

WERE EXPENSES INCURRED FOLLOWING AN ACCIDENT? ❑ YES ❑ NO IF YES, PLEASE SPECIFY:

DATE: _____ PLACE: _____

CIRCUMSTANCES: _____

_____

ARE EXPENSES SUBMITTED COVERED BY ANY OTHER INSURANCE CONTRACT? ❑ YES ❑ NO

IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ❑ YES ❑ NO

IF YES: _____ _____

CONTRACT NUMBER — INSURER'S NAME

N.B.: THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT HIS CLAIM TO HIS INSURER. AFTERWARDS, PROVIDE BLUE CROSS WITH A COPY OF YOUR RECEIPTS WITH A DETAILED ACCOUNT OF BENEFITS PAID. FURTHERMORE, CLAIMS FOR CHILDREN MUST BE SUBMITTED TO THE INSURER OF THE PARENT (FATHER OR MOTHER) WHOSE BIRTHDAY OCCURS FIRST IN THE CALENDAR YEAR.

HEALTH SPENDING ACCOUNT (please complete the following if you want to use your Health Spending Account)

Please reimburse any unpaid or non-eligible portion of this Health Insurance claim ❑ and/or Dental Care Insurance ❑ through my HealthSpending Account

I hereby certify that the expenses submitted were incurred following an illness or injury and that my statements are true and complete.

If the claim is submitted on behalf of my spouse or dependent children, I confirm that I am authorized to release any information regarding the latter for the purpose of claim processing.

I authorize Blue Cross to obtain and use all pertinent information relevant to the claim processing and the administration of the plan.

I authorize any person or organization, including health care providers or any health professional, medical organization holding relevant information in respect of this claim, to release and exchange the information that is requested by Blue Cross or its agents.

I understand that my personal information will be kept confidential and secure and will be used only for the reason it was provided for.

I understand that a photocopy or electronic version of this authorization is as valid as the original.

Signature _____ Date _____

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws.

IF YOU ARE CLAIMING FOR A DEPENDENT CHILD (AGED 18 OR 21 AND OVER BUT UNDER 25) PLEASE PROVIDE THE FOLLOWING INFORMATION:

GIVEN NAME	NAME OF SCHOOL, COLLEGE OR UNIVERSITY BEING ATTENDED	SEMESTER	FULL TIME	PART TIME

* PLEASE INDICATE THE TOTAL AMOUNT SUBMITTED FOR EACH PATIENT, PER CALENDAR YEAR.

GIVEN NAME	DATE OF BIRTH DD	MM	YY	SEX	RELATIONSHIP	AMOUNT SUBMITTED	CALENDAR YEAR	**FOR BLUE CROSS USE ONLY**
					TOTAL			