HEALTH CLAIM FORM

Plan Member's Full Name:	Group or Employer	Personal Identification No. Group # I.D.# Date of Birth Day / Month / Year

Plan Member's Address Street _____ Apt. _____

City _____

Province _____ Postal Code _____ Telephone No. _____

Language Preference
☐ English
☐ French

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth			Relationship to Plan Member
	Day	Month	Year	
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyy)	Recommended by: Physician's name	Amount

Total Claim $ 0.00

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? Yes ☐ No

2 b. Name of other insuring agency or plan _____

2 a. If yes, indicate member under other plan: ☐ Self ☐ Spouse

Policy No. _____ Certificate No. _____

Name _____ Date of Birth Day Month Year

N.B. **For coordination of benefits**, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

3. Do you want any unpaid balance from this claim reimbursed from your health service spending account (if eligible)? ☐ Yes ☐ No

*** Note: Do NOT staple or tape receipts to the claim form ***

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Date_____ **Plan Member's Signature**_____

All information recorded on this form is confidential

Send all claims and inquiries to:

CLAIMSECURE INC.

PO BOX 6500 STN A SUDBURY ON P3A 5N5 1-888-513-4464