GROUP HEALTH CLAIM FORM

Employee: Complete this section. Please print.

1. Employer _____

2. Employee's name _____ Date of Birth Day / Month / Year _____

3. Address _____ Certificate [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
Street

_____ Postal Code _____
City Province

Is this an address change? ☐ Yes ☐ No

Phone Number ( ) _____

4. If you are making a claim for a Dependent, please provide the following information:

Name	Date of Birth Day	Month	Year	Relationship (Spouse/Child)	Is Dependent Working? (Yes or No)	Is Dependent in School? (Yes or No)	If working, provide name of employer If in school, provide name of institution

5. Are group health benefits payable from any other source? ☐ Yes ☐ No Name Source _____

6. Are any expenses due to sickness or injury arising out of any employment of the member or dependent? ☐ Yes ☐ No

If "yes", provide date and details _____

Is claim being made for Workplace Safety Insurance Board benefits? ☐ Yes ☐ No

7. Name and address of prescribing physician(s). _____

ORIGINAL RECEIPTS MUST BE ATTACHED TO THIS FORM

8. Total amount of this claim:

$ _____

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief, and that the attachments to this form are receipts in connection with the medical treatment of the above named individuals. I understand that the Plan Administrator will use the information provided by me on this claim form strictly for the purpose of processing my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize the Plan Administrator to evaluate or investigate my claim, and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my employer, any licensed physicians or other health professionals, any medical facility, any insurance company or government body, and any other person or institution to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Employee's signature _____ Date _____

Employee: submit completed claim form and original receipts to:	For Plan Administrator Use Only - Do not write in this area. -
Manion, Wilkins & Associates Ltd. 626 - 21 Four Seasons Place Etobicoke, Ontario M9B 0A6	**Plan Number:**