



CLAIM FORM FOR EXTENDED HEALTH BENEFITS

PART 1 EXPENSES

Table with 4 columns: NAME OF PERSON INCURRING EXPENSE, PRESCRIPTION NAME NUMBER OR DESCRIPTION OF EXPENSE, DATE EXPENSE INCURRED D/M/Y, AMOUNT PAID

INSTRUCTIONS

- 1. Employee fully complete Parts 1 & 2.
2. Attach original receipts for all expenses being claimed.
3. If further information is required, please use separate paper.
4. If required, return the completed form to your Human Resource or Payroll Department for completion of Part 3.
Incomplete information will mean a delay in processing. Please make sure everything is complete and accurate and all original receipts are attached. Thank you.

PART 3 EMPLOYER/POLICY HOLDER

COMPLETE IF EMPLOYER'S/POLICYHOLDER'S AUTHORIZATION REQUIRED

Form with fields: CLASSIFICATION, DATE EMPLOYED, TERMINATED DATE, EMPLOYEE'S EFFECTIVE DATE, DEPENDENT'S EFFECTIVE DATE, NAME OF EMPLOYER/POLICYHOLDER, STATUS, SIGNATURE OF AUTHORIZED OFFICIAL, DATE

ASSIGNMENT OF BENEFITS

I hereby assign any benefits payable for eligible services or medical supplies provided by: _____, _____, _____, _____, and authorize direct payment to said provider/s.

X _____ Employee's Signature

PART 2 EMPLOYEE & DEPENDENT DATA

Group Policy No.: _____ Account No.: _____ PID #: _____ Employer/Policyholder Name: _____

1. Employee's name (first, initial, last) Previous name (if applicable)
2. Employee's mailing address (D, M, Y, Street, City, Prov, Postal Code)
3. Date of Birth
4. Is this your first group insurance claim with The Co-operators?
5. Are you actively at work?
6. Are benefits for any of these expenses payable from any other company or source such as your employer or Worker's Compensation?
7. Dependent Data: Name, Sex (M/F), Date of Birth, Relationship, Student, Handicapped

If dependent is a student over the age 18, name of student, name of school, Student status, Will student be graduating at the end of the semester indicated?

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I hereby certify that each of the listed drugs or expenses were purchased or incurred in connection with medical treatment of the above mentioned individuals. I authorize physicians, hospitals, pharmacies and others to release full information with respect to this claim

X _____ Employee's Signature X _____ Date