Clarica Life Insurance Company / Waterloo, Ontario

CLARICA™

EXTENDED HEALTH CLAIM FORM

A. PLAN MEMBER INFORMATION

Name of Employer ____________________

Plan Member's Name ____________________ (in full)

Address ____________________ Street/Apt.#/RR#

Date of Birth |_|_|_|_|_|_|_|_| Day Month Year

Sex ❑ F ❑ M

Section ____________

____________________ City Province

Member ID. |_|_|_|_|_|_|_|_|_|

Policy/Plan No. ____________

____________________ ( ) Postal Code Phone No.

B. CO-ORDINATION OF BENEFIT INFORMATION

Co-ordination of Benefits is a method used by the insurance industry to determine the order of paying benefits when the spouse and children are covered under more than one group insurance plan . For example, a spouse who is covered under his/her employer's plan must submit claims to that employer's plan first, and a university student who is covered under a university plan must submit claims to the university plan first. Expenses for your children must be submitted under the plan of the parent with the earlier month, then day of birth in the calendar year.

Refer to your employee booklet or contact your plan administrator for more information about Co-ordination of Benefit guidelines.

1. Are any of the expenses being claimed covered by another group insurance plan? ❑ No ❑ Yes. If yes, complete the following information about **the person who is the MEMBER under the other plan:**

   Other Member's Name ____________________ (in full) Cert./ID No. ____________ Date of Birth |_|_|_|_|_|_|_|_| Day Month Year

   Insurance Company's Name ____________________ Policy/Plan No. ____________

2. If your health coverage under another group insurance plan has been cancelled, please give the cancellation date: |_|_|_|_|_|_|_|_| Day Month Year

C. ACCIDENT INFORMATION

Are any of the expenses being claimed due to an accident? ❑ No ❑ Yes. If yes, did the accident happen at work? ❑ No ❑ Yes.

Please provide a letter:
- explaining the details of the accident, and
- indicating if another party is liable.

Date of the accident |_|_|_|_|_|_|_|_| Day Month Year

D. DRUG EXPENSES

FOR CLARICA'S USE

Patient's Usual Name	Relationship to Plan Member			Date of birth			Children Only, Check if:		Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	Self	Spouse	Child	DD	MM	YYYY	full-time university or college student	disabled		
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$

E. OTHER EXPENSES (Excluding Drugs)

Patient's Usual Name	Relationship to Plan Member			Date of birth			Children Only, Check if:		Type of Expense	Amount Charged for Each Expense	Date of Visit or Purchase			Practitioner's or Supplier's Name
	Self	Spouse	Child	DD	MM	YYYY	full-time university or college student	disabled			DD	MM	YYYY	
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				

TOTAL OF ALL DRUG AND OTHER EXPENSES → $

Have you stapled all ORIGINAL receipts to the BACK of this form? We need these to process your claim.

F. AUTHORIZATION

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I authorize the release, by any health care provider, Clarica or any of its agents, of any information necessary for the administration of this claim or my group plan. This may include the release of information to pharmacies, physicians or dentists to promote the safe and effective use of drugs. A photostat of this authorization is as valid as the original.

Plan Member's Signature ✘

Date |_|_|_|_|_|_|_|_| Day Month Year

G. MAIL COMPLETED FORM TO:

British Columbia and Yukon Territory Residents
CLARICA
HEALTH AND DENTAL CLAIMS
PO BOX 9570 STN MAIN
VANCOUVER BC V6B 6N2

Alberta, Sask., and N.W.T. Residents
CLARICA
HEALTH AND DENTAL CLAIMS
PO BOX 2510 STN M
CALGARY AB T2P 5C7

Manitoba, Ontario, Nunavut, Nova Scotia, New Brunswick, P.E.I. and Nfld. Residents
CLARICA
HEALTH AND DENTAL CLAIMS
PO BOX 3413 STN D
OTTAWA ON K1P 1G8

Québec Residents
CLARICA
REGIONAL GROUP CLAIMS OFFICE
1550 METCALFE ST SUITE 1004
MONTRÉAL QC H3A 1X6

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.