National Life

Health Benefits Claim

When accumulated bills exceed the deductible, complete form, attach bills and forward to:

National Life
Group Claims
522 University Avenue
Toronto, Ontario M5G 1Y7

- Original receipts, not photocopies, MUST accompany this claim form.
- Claims for medical appliances or prosthetics MUST BE accompanied by the Physician's prescription and diagnosis.

Your Name	
Your address	Name of Employer

LIST BILLS BELOW, GROUPED BY INSURED PERSON, IN DATE ORDER

Name (Employee or Insured Dependent)	Relationship to employee	Birth Date	Date of Bill	Drug or Item Prescribed	Prescription No.	Amount Charged

NOTE: BIRTHDATE FOR ALL DEPENDENTS (SPOUSE AND CHILDREN) MUST BE GIVEN.

TOTAL

Group no.	Division/Location no./Class	Certificate no.

If dependent is a child, age 21 or older, **the name of the educational institute he/she is attending MUST be given below.**

☐ Full-time
☐ Part-time

Are any benefits or services provided under any other group insurance or supplementary health plan ☐ Yes ☐ No	If "Yes", indicate Policy number : Name of insuring agency:

Are the charges covered by the Provincial Hospital and/or Medicare Plan? ☐ Yes ☐ No	If "Yes", when did the claim exceed the Plan's maximum:

Are any of the above expenses the result of a motor vehicle accident?
☐ Yes ☐ No

I hereby declare to National Life the above details are true to the best of my knowledge and belief and authorize any physician or pharmacist listed above to disclose to National Life any information regarding these expenses which they may need in their assessment of my claim for benefits.

I AUTHORIZE National Life to use my Social Insurance Number for identification purposes in the handling of my claim. In addition, I also AUTHORIZE my Employer and National Life (including its affiliates and/or reinsurers) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Group Insurance Policy issued by National Life. A photostatic or carbon copy of this authorization shall be as valid as the original.

Signature of insured employee	Date signed

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL