

HEALTH CARE CLAIM FORM

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors

NOTE: Attach all original receipts (photocopies or carbon copies are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc. If you need additional space attach a second form.

PART 1: EMPLOYEE / PLAN MEMBER / SUBSCRIBER INFORMATION			
EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE SURNAME	GIVEN NAME	
ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE

PART 2: EMPLOYER INFORMATION			
PLAN NUMBER	DIVISION NO.	NAME OF EMPLOYER	
ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE

PART 3: CO-ORDINATION OF BENEFITS AND OTHER DETAILS		
1. Are you or any other member of your family entitled to benefits under any other plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", provide name of family member insured:		
Relationship to employee:		
Name of other insurance company:		Policy No:
2. Is any member of your family (other than yourself) insured as an employee under this plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you have answered yes to question 1 or 2 please provide your spouse's date of birth: (M/D/Y)		
3. Are claims being submitted as a result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes" give date, location and brief explanation of how the accident happened:		
4. Are any expenses related to an illness / injury that is work related?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Would you like any unpaid balance to be reimbursed from your Health Spending Account /Cost Plus Account (If Applicable)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PART 4: PRESCRIPTION DRUG DETAILS						
Patient Name	Relationship to Employee	Date of Birth (M/D/Y)	Is child a fulltime student or disabled?	No. of Receipts Per Patient	Total Drug Amount Charged Per Patient	

PART 5: OTHER HEALTH EXPENSES						
Patient Name	Relationship to Employee	Date of Birth (M/D/Y)	Is child a fulltime student or disabled?	Type of Expense	Amount Charged	Date of Visit or Purchase

PART 6: AUTHORIZATION & SIGNATURE

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN REPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. THE CLAIM INFORMATION WILLINGLY PROVIDED BY ME TO WILSON BENEFITS LTD.. HELD IN THEIR FILE WILL BE USED BY WILSON INSURANCE LTD. FOR THE PURPOSES OF CLAIMS PROCESSING AND ADJUDICATION. I UNDERSTAND AND AUTHORIZE THAT FOR THE ABOVE PURPOSES THE PERSONAL INFORMATION ON FILE IS ACCESSIBLE TO, AND MAY BE EXCHANGED WITH, AUTHORIZED EMPLOYEES OF AND RELEVANT THIRD PARTIES RETAINED BY WILSON INSURANCE LTD., ITS SALES DISTRIBUTION NETWORK, PARTICIPATING RE-INSURER (S), OTHER INSURANCE COMPANIES, INVESTIGATIVE ORGANIZATIONS, HEALTH CARE PROVIDERS, INCLUDING, BUT NOT LIMITED TO, PHARMACIES, PYSICIANS, DENTISTS, AND ANY OTHER PERSON OR PARTY WHOM I AUTHORIZE. IF APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION LSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES. I UNDERSTAND THAT CLAIMS MADE UNDER THE GROUP POLICY ARE SUBMITTED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE WILSON INSURANCE LTD. TO EXCHANGE INFORMATION ABOUT THESE CLAIMS WITH ME OR ANY PERSON ACTING ON MY BEHALF, INCLUDING A SPOUSE OR DEPENDENT, AS DEEMED NECESSARY FOR THE PURPOSE OF CONFIRMING ELIGIBILITY AND ASSESSING AND MANAGING THE CLAIM.

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

DATE (DD/MM/YYYY)