

1. Statement of Participant

(to be completed in full by the Claimant)

1.1 Policy No.: _____ 1.2 Certificate No.: (if known) _____

1.3 Participant Name _____ 1.4 Date of Birth D M Y
First Name Last Name

1.5 Is the participant retired? Yes No

1.6 Address _____
Street City Province/Country Postal Code

1.7 Email _____

To be completed by Participant who is claiming for his/her dependent children. (Please complete one claim form per child)

1.8 Dependent Name _____ Relationship to Participant _____ Date of Birth _____
D M Y

Claimant's Signature (if over 18 years old) _____

1.9 Does he/she permanently reside with you? Yes No Is your dependent child married? Yes No
 Is he/she in attendance at University or College? Yes No If "Yes", give name and address of school _____

1.10 Is the claimant insured under a provincial health plan? Yes No - If "No", please provide an explanation _____

1.11 Does the claimant have any other health insurance? Yes No - If "Yes", please give name and address of company
 Policy Number _____ Type of Coverage _____

1.12 Employer's Name _____ 1.13 Telephone No. () _____

1.14 Employer's Address _____

2. Direct deposit

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

Bank # _____ Transit # _____ Account # _____ **Please attach a "Void" cheque**

3. Remit payment to provider

(To be completed by the participant if cheque is to be made payable to the Provider)

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

Signature of Participant _____ Date D M Y Telephone Number () _____

