BLUE CROSS® CANASSURANCE

Claim Form

Extended Health Care Benefit
Medical and Paramedical Fees

IDENTIFICATION

Name of the policyholder:_____

Policy No.: _____ Certificate No.: _____

Address:_____

Telephone No.:_____ ❑ Home ❑ Mobile Email: _____

INFORMATION ON EXPENSES INCURRED

1. Were expenses incurred following: ❑ an accident ❑ an illness In case of an accident, please specify:

   Date (dd / mm / yyyy): _____ Location: _____

   Circumstances:

2. Are the expenses submitted covered by any other insurance contract? ❑ yes ❑ no If yes:

   Name of the insurer:_____ Contract No.: _____ Name of the insured:_____

3. The expenses submitted were incurred for:

   ❑ a spouse

   The spouse covered by another health insurance plan must first submit a claim to his/her insurer, then provide Blue Cross Canassurance with a copy of the receipts with detailed account of benefits paid.

   ❑ a dependent child Please provide a proof of the status of full time student.

   Claims for children must be submitted to the insurer of the parent (father or mother) whose birthday occurs first in the calendar year.

DECLARATION

I hereby declare that , to the best of my knowledge, the statements above are true and complete.

Signature:_____ Date (dd / mm / yyyy):_____

Signature of policyholder if the insured person in less that
16 years of age in Ontario or less than 14 years of age in Québec_____ Date (dd / mm / yyyy):_____

Please provide information on your medical fees on the following page. After printing the form, please sign and date and attach the original receipts. We suggest that you make a copy of these documents as they will not be returned to you.

Mail your claim and receipts to:

In Québec
Blue Cross Canassurance
PO Box 1630, Station B
Montréal, Québec H3B 3L3

In Ontario
Blue Cross Canassurance
PO Box 4433, Station A
Toronto, Ontario M5W 3Y7

INSURED CONCERNED BY THIS CLAIM

Policyholder: _____ Spouse: _____

Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑ Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑

Dependent child 1: _____ Dependent child 2: _____

Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑ Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑

Dependent child 3: _____ Dependent child 4: _____

Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑ Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑

Dependent child 5: _____ Dependent child 6: _____

Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑ Date of Birth (dd / mm / yyyy): _____ Gender: M ❑ F ❑

INSURED CONCERNED BY THIS CLAIM

Please enter the expenses incurred per insured.

Frist name	Calendar year	Amount submitted		Frist name	Calendar year	Amount submitted
Sub		$0.00		**Sub**		$0.00
				Grand total		$0.00

For any questions, please contact us prior to forwarding your claim in order to avoid any unnecessary delays. Please note that calls to our Claims Department are recorded for training, quality control and verification purposes.

Blue Cross Canassurance
Claims, Individual Health Insurance
Telephone: 1-844-904-8353