

Medical Expense Claim

To be completed by claimant

Name of Policy holder:	Policy no.	
Name of Insured:	Email Address:	
Name of Claimant (If other than above):		Relationship to Insured
Address:		Telephone no.

1) Does the claimant have medical insurance under any other plan? (Including Spouse's Insurance and/or government health plan).

- NO**
 YES

	Policy no.
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2) Are any expenses submitted as the result of an accident?

- NO**
 YES

If yes, please provide details, including date and location of accident:

3) Please provide a diagnosis for each bill submitted:

Date of Service	Charges	Diagnosis/Condition/Illness

4) Has the claimant ever had same or similar condition:

- NO**
 YES

If yes, state when and describe: _____

5) How do you wish reimbursement to be made? Cheque Direct Deposit (your bank may impose a service fee) If

Direct Deposit: Name of Bank _____ Bank Number _____
 Branch Address _____ Transit Number _____
 Name of account holder _____ Account Number _____

Please complete this form in its entirety, answering all sections and submit only original bills to the above address.

I authorize the release of any information requested in respect of this claim to the Insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

Signature (Claimant)

Date