



EXTENDED HEALTH CLAIM

Please print your Firm & Certificate #

Firm # Certificate #

EMPLOYEE INFORMATION

Firm Name

Employee's Full Name

Home Mailing Address

Apartment/Street

City / Town

Province

Postal Code

Please provide a phone number where we can reach you during the day if we have any questions about your claim. ()

Table with 5 columns: Patient's Name, Birthday M/D/Y, Relation to Employee, Service Type, Total Amount Charged/Patient. Includes a Total row at the bottom right.

CO-ORDINATION OF BENEFITS

Are you claiming for a dependent child who is age 21 or older? No Yes

Child is physically/mentally handicapped (medical evidence may be requested)

a student enrolled full time at (school's name)

Are you or your dependents entitled to health benefits under any other plan? No Yes If "Yes," family member insured

Name of insuring company Spouse's birthdate

M/D/Y

ACCIDENT INFORMATION

Are any of the services provided as a result of an accident? No Yes If "Yes," enclose a brief description of the date and details of the accident.

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility.

Signature of Employee Date

ALL INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL

Please mail this completed form and your original receipts to Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1 1-800-665-3365 Insuring Company: Desjardins Financial Security



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INSTRUCTIONS (Please read carefully)

We need your original receipts, **OR** the Explanation of Benefit statement and copies of receipts from any plan that has already paid a portion of the expense, to process your claim. Please staple your receipts or statement with copies to this form. **We do not return original receipts.**

Receipts must include the service date; a complete breakdown of charges; and the practitioner's name, credentials, address, and phone number.

Before mailing this form, make sure all questions on this form are answered. If you send an incomplete form, your claim may take longer to process.

Expenses paid by your group benefit plan are not eligible income tax deductions. You may be eligible to claim any amounts not covered by the Plan. Your Explanation of Benefits will be accepted as proof of amounts not covered by the Plan.



WANT TO GET YOUR CLAIM PAID FASTER? SIGN UP FOR DIRECT DEPOSIT!

Receive your claim payments faster with direct deposit.

- Go to www.my-benefits.ca and register for the Plan member secure site
- Once you've registered, or if you're already registered, log in and select **DIRECT DEPOSIT** under **YOUR PROFILE** from the menu on the left
- Enter your banking information