



HEALTH CARE EXPENSE FORM

Mail Claims to:
 AccertaClaim Servicorp Inc.
 Station "P", P.O. Box 310
 Toronto ON M5S 2S8

Instructions: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanations for Income Tax purposes.

Use one claim form per person. This claim form is to be used for extended health, prescription drug and vision claims only. Dental claims must be completed by your dentist and submitted on a dental claim form.

Important: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. Ensure all invoices are submitted within 120 days from the Date of Service (not required for AccertaFlex plan).

Part 1 – Member Information PLEASE PRINT

Group Number	Company Name		
Member ID# (not required for AccertaFlex Plan)	Member Name	Date of Birth dd/ mm/ yy/	
Street Address:			Home Tele No:
City	Province	Postal Code	Business Tele No.

Part 2 – Recipient Information

Recipient ID # (not required for AccertaFlex Plan)	Recipient Name	Relationship	Date of Birth dd/ mm/ yy/
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Part 3 – Claim Details - For equipment and appliance expenses, AccertaClaim requires a statement or invoice from the Service Provider and a copy of the provincial plan statement of payment (if applicable).

Number of Receipts	Date of Service	Provider Number	Types of Expenses	Total Charge

Part 4 – Co-ordination of Benefits (not required for AccertaFlex plan)

Are you or any other member of your family entitled to benefits or services provided under any other Group Insurance, WCB or Government Plan? Yes No

If "Yes", name of family member insured _____

Relationship to employee _____

Name of other insurance company _____

Policy Number _____

Is treatment required as the result of an accident? Yes No

If "Yes", give date _____ and location _____

And explain how accident happened _____

Is a claim being made for Worker's Compensation Benefit? Yes No

Part 5 – Authorization

I authorize release of any information requested in respect of the claim to AccertaClaim Servicorp Inc. or its agents and certify that the information given is accurate and complete to the best of my knowledge. I authorize its use for the identification and administration of my group benefits. I also authorize the communication of information related to the coverage of services described in this form to the named dentist. As the signee, I am the patient or the guardian.

Signature _____ Date _____