COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd. is a People Corporation company

MEDICAL EXPENSE CLAIM FORM

INSTRUCTIONS

1. Complete this form for **all** medical expenses and services. For dental expenses, complete the *Dental Expense Claim Form.*
2. Print clearly and ensure that all required sections are completed. An incomplete form may result in a delay in processing.
3. Attach the **original** receipt for each expense claimed and retain a copy for your records.
4. Sign and date the form and return to Coughlin & Associates Ltd. for processing.

Mailing address
PO Box 764
Winnipeg, MB R3C 2L4

Tel: 204-942-4438
1-888-204-1234

www.coughlin.ca

1. PLAN MEMBER INFORMATION

Plan sponsor/Group name			Member ID/PIN	
Member last name	Member first name	Member middle initial	☐Male ☐Female	Date of birth (yyyy/mm/dd)
Mailing address		City	Province	Postal code
Email address	Primary telephone	Secondary telephone	Language of correspondence	☐English ☐French

2. COORDINATION OF BENEFITS How to submit a claim when there are two (or more) benefits plans

Is the named patient entitled to benefits under any other plan for the expenses being claimed? ☐Yes ☐No
If yes, provide the following information:

- Who does the other plan belong to? ☐ Self ☐ Spouse ☐ Ex-spouse ☐Full-time student

First name	Last name	Date of birth (yyyy/mm/dd)
Name of insurance company	Plan number	Plan member ID number

- If other coverage pertains to a dependant child, please provide spouse's (or ex-spouse's) date of birth (yyyy/mm/dd) _____
- If other coverage is also with Coughlin, do you want us to process the claim through both benefits plans? ☐Yes ☐No

- Send your claims to your own plan first. When you receive your explanation of benefits, send it along with copies of your receipts to the other plan to claim any unpaid amount.
- Send your spouse's claims to their plan first, then send a copy of their explanation of benefits and receipts to your plan.
- Send your dependant children's claims first to the plan of the parent whose birthday (month and day) occurs first in the calendar year.

Are any of the expenses associated with a work-related incident AND eligible for workers' compensation benefits? ☐Yes ☐No
If yes, submit these expenses to your provincial workers' compensation board.

3. CLAIM INFORMATION For equipment and appliance expenses, a written recommendation from the prescribing physician is required, including diagnosis and a copy of the provincial plan statement of payment (if applicable).

Patient last name	Patient first name	Type of expense	Date of birth (yyyy/mm/dd)	Relationship to plan member	Full-time student	Disabled child	Amount claimed
		☐Drug ☐Other ☐Vision			☐Yes ☐No	☐Yes ☐No	$
		☐Drug ☐Other ☐Vision			☐Yes ☐No	☐Yes ☐No	$
		☐Drug ☐Other ☐Vision			☐Yes ☐No	☐Yes ☐No	$
		☐Drug ☐Other ☐Vision			☐Yes ☐No	☐Yes ☐No	$

4. VISION CARE EXPENSES Complete only if submitting a vision care expense

Is this a new prescription? ☐Yes ☐No

Check one (if applicable) ☐ Occupational safety glasses ☐ Prescription sunglasses ☐ As a result of cataract surgery (attach physician's recommendation)

5. HEALTH CARE SPENDING ACCOUNT Complete only if you have this benefit

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Care Spending Account (HCSA). I understand that I must first submit my claim using the co-ordination of benefits with my spouse's plan, if applicable.

☐ I do not wish to use my HCSA ☐ I wish to use my HCSA to cover the expenses that are not reimbursed under my group insurance plan

6. OTHER INFORMATION

Attach your original receipts to this form and keep photocopies for your files. The original copies will not be returned. Your explanation of benefits and the copies of your receipts are sufficient for coordination of benefit purposes. Claims MUST BE submitted no later than the period defined in your benefit booklet.

7. CLAIM AUTHORIZATION & DECLARATION

I certify that:
(1) The information in this form is true and complete and does not contain a claim for an expense previously paid under any benefits plan.
(2) The goods and services being claimed have been received by the named patient.
(3) I am authorized to disclose the information about any other person identified on this form and to consent to the collection, use, and disclosure of their personal information as described below.
(4) The named patients authorize Coughlin & Associates Ltd. to disclose information about their claims to me for the purpose of assessing, investigating, and paying the claimed benefits, and managing my group benefits plan.
(5) If I am making a claim under my Health Care Spending Account, I certify that these expenses qualify for reimbursement.

I understand that:
(1) This claim may be audited and investigated.
(2) I may be contacted to obtain additional information, if required to process or investigate this claim.
(3) This claim may de declined and my coverage under my benefit plan may be terminated if this claim contains, or I subsequently provide false, incomplete, or misleading information.
(4) If any tax consequences arise from reimbursement of expenses under my Health Care Spending Account, I am responsible for payment of those taxes.

I agree that a photocopy or electronic copy of this form is as valid as the original.

8. AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PERSONAL INFORMATION

When necessary for the purposes of administering, underwriting, adjudicating, managing, auditing, and investigating this claim, I authorize Coughlin & Associates Ltd., and its parent company, People Corporation to:

(1) collect and use the personal information provided on any form related to this claim.
(2) collect any additional personal information from any person or organization who has information relevant to this claim, such as health care providers and institutions, insurers, investigators, my employer or former employers, and benefit plan sponsor or trustees.
(3) disclose this personal information to any person or organization, such as health care providers, Coughlin & Associates Ltd.'s affiliated companies, insurance companies and their reinsurers, service providers, my employer or former employers, benefit plan sponsor or trustees, and investigators.

If there is a suspicion of fraud or benefit plan abuse related to this claim, or if I or a named patient have received an overpayment or otherwise obtained a benefit related to this claim to which we are not entitled, this personal information may be used and disclosed to other persons or organizations, including investigators, law enforcement, collection agencies, professional regulators, credit reporting services, the provider of the claimed product or service, and my employer, or the benefit plan sponsors or trustees for the purposes of preventing fraud or abuse, investigating the suspicion or recovering the amount of the overpayment or benefit. In addition to any other remedies available to Coughlin & Associates Ltd., if I or a named patient have received an overpayment or otherwise obtained a benefit related to this claim to which we are not entitled and have not reimbursed Coughlin & Associates Ltd., I authorize the recovery of the amount of the overpayment or benefit from any amount payable to me under my benefit plan.

I understand that any audit authorization is only valid for the duration of the benefit plan related to this claim. Otherwise, the authorization is valid as long as this claim is being processed and as long as I am receiving benefits related to this claim, or until I revoke my authorization in writing. I also understand that if I revoke this authorization this claim will not be processed and I will not be entitled to receive any further benefits related to this claim.

Member signature	Date (yyyy/mm/dd)

Protecting your personal information. We recognize and respect your right to privacy. When personal information is provided to us, we establish a confidential file that is kept in our facilities or in the facilities of an organization that we authorize. We limit access to information in your file to our personnel or other persons we authorize, who require the information to perform their duties with respect to your benefit plan, to persons to whom you have granted access, and to persons authorized by law. If you require more detail about how we protect your personal information or the other persons to whom we disclose your personal information, you may access our Privacy Policy at https://www.peoplecorporation.com/privacy/ or contact our privacy officer using the contact information below.

Contact Information:
Coughlin & Associates Ltd.
1403 Kenaston Blvd., Winnipeg, MB, R3P 2T5
Attn: Privacy Officer

Email: privacy.officer@peoplecorporation.com