HEALTH CLAIM FORM

Plan Member's Full Name:	Group or Employer	Personal Identification No. Group# I.D.# Date of Birth Day / Month / Year

Plan Member's Address

Street _____ Apt. _____

City _____

Province _____ Postal Code _____

Email: _____

Language Preference
English ☐
French ☐

Telephone No. _____

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENT

Dependent's name (Last, First)	Date of Birth			Relationship to Plan Member
	Day	Month	Year	
				Spouse ☐ Daughter ☐ Son ☐ Other (describe):_____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe):_____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe):_____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe):_____

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyyy)	Recommended by: Physician's name	Amount

Total Claim $

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? Yes ☐ No ☐

2 b. Name of other insuring agency or plan_____

_____

2 a. If yes, indicate member under other plan:
Self ☐ Spouse ☐

Policy No. _____ Certificate No. _____

Name _____ Date of Birth ☐☐☐☐☐☐
Day Month Year

N.B. **For coordination of benefits**, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

3. Do you want any unpaid balance from this claim reimbursed from your health service spending account (if eligible)? Yes ☐ No ☐

*** Note: Do NOT staple or tape receipts to the claim form ***

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. If I am submitting personal information about myself and/or my spouse and/or dependents, I acknowledge that I/he/she/we/they have reviewed and consent to the Disclaimer and Privacy Policy (https://www.claimsecure.com/privacy/). I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan. I understand and agree that ClaimSecure will conduct audits of claims submitted by me for purposes including, but not limited to, preventing and detecting fraud. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose this claim, or any personal information contained in this claim, to the benefit plan sponsor/employer for the purposes of reporting fraud suspicious claims. I am aware that under certain circumstances permitted by law, ClaimSecure, or persons acting on its behalf, may be required or permitted to disclose this claim, and the information contained in this claim, including personal information, to others without my knowledge or consent, or the consent of the individual to whom the information relates. In all other circumstances, ClaimSecure will only disclose such personal information in accordance with ClaimSecure's Privacy Policy (https://www.claimsecure.com/privacy/). We may revise this Disclaimer from time to time, and will post the most current version on our website at (https://www.claimsecure.com). Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Disclaimer. We will indicate at the top of the page the date this Disclaimer was last revised. Your continued use of our services after any such changes constitutes your acceptance of the Disclaimer as revised.

Date: _____ Plan Member's Signature: _____

All information recorded on this form is confidential

Send all claims and inquiries to:

CLAIMSECURE INC.

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service@claimsecure.com