



MAIL TO: Group Extended Health Care Claims
The Co-operators, 1920 College Ave., Regina, SK S4P 1C4

EXTENDED HEALTH CARE BENEFIT CLAIM FORM

INSTRUCTIONS

- 1. Complete the section headed "Description of Expenses".
2. Remember to include a copy of the "Physician's Recommendation", if required.
3. Part 2 must be completed.

ASSIGNMENT OF BENEFITS

I hereby assign any benefits payable for eligible services or medical supplies provided by: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and authorize direct payment to said provider/s.

X \_\_\_\_\_
Employee's/Member's Signature

PART 1 DESCRIPTION OF EXPENSES (Attach Original Receipts)

Table with 7 columns: NAME OF PERSON INCURRING EXPENSE, SEX, DATE OF BIRTH, RELATIONSHIP, DESCRIPTION OF EXPENSE, DATE EXPENSE INCURRED, AMOUNT PAID

PART 2 EMPLOYEE/MEMBER STATEMENT (Please Print)

Group Policy No. Account No. PID # Name of Employer/Policyholder

- 1. Employee's/Member's name (first, initial, last) Previous name (if applicable)
2. Employee's/Member's mailing address (Street, City, Prov, Postal Code)
3. Date of Birth (D/M/Y)
4. Are benefits for any of these expenses payable from any other company or Worker's Compensation?
5. If your Plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account?
6. If claimant is a student over the age 18, name of student, name of school, Student status, Enrolled in the semester starting and ending (date). Will student be graduating at the end of the semester indicated?

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim.

X \_\_\_\_\_
Employee's/Member's Signature

X \_\_\_\_\_
Date

PART 3 EMPLOYER/POLICYHOLDER (Only If Authorization Required)

Employee's/Member's Effective Date (D/M/Y) Dependant's Effective Date (D/M/Y) Termination Date (D/M/Y) (If applicable)
Signature of Employer/Plan Administrator Official Classification Date