

**MAIL TO: Green Shield Canada**  
 Attn: Drug Dept, P.O. Box 1652, Windsor, ON N9A 7G5

**PAY-DIRECT DRUG CLAIM FORM - MANUAL SUBMISSION**

**INSTRUCTIONS**

1. This form is only to be used by subscribers insured under Co-operators Pay Direct Drug Card Plans.
2. Complete Subscriber Statement
3. **PLEASE INCLUDE ORIGINAL PHARMACY RECEIPTS.**
4. Retain copies of all receipts for your records. Original receipts will not be returned.
5. Additional claims forms can be obtained from your Plan Administrator or visit; [www.cooperators.ca/life/group](http://www.cooperators.ca/life/group)

**PART 1 SUBSCRIBER STATEMENT (Please Print)**

1. Group number OR Company Name \_\_\_\_\_

2. Subscriber Surname including alternate surname if applicable \_\_\_\_\_

3.

Drug Card Identification Number	Patient's First Name	Birth date																									
		Year	Month																								
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4. Street Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Country \_\_\_\_\_

Postal Code 

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 Telephone 

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5. Do you have any other insurance that may reimburse these expenses as a benefit? YES  NO   
 If yes, indicate name of other insurer \_\_\_\_\_

6. Are any of the enclosed claims due to a work related injury? YES  NO   
 Are any of the enclosed claims due to a Motor Vehicle Accident? YES  NO

**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. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. Any copy of this authorization shall be as valid as the original.

X \_\_\_\_\_  
 Subscriber Signature

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