

CLAIM FORM TO BE USED FOR:
HEALTHCARE EXPENSES

**To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses.
(Please attach to the back of this form). Please retain copies for your files as original receipts will not be returned.**

Plan Name or Employer Name (if applicable)				Client Number:		Birthdate		
Insured – Last Name:			Insured – First Name:			Yr	Mo	Day
Address: Number and Street		City	Province	Postal Code	Home Number:	Work Number:		

CLAIM DETAILS	-All drug receipts must contain the drug identification number (D.I.N) and the name of the prescription drug. -All vision care expenses must have itemized the patient's name, cost of glasses/contacts, dispensing fee, cost of eye exam, date of eye exam, treatment and date dispensed. -All practitioner/paramedical expenses must have itemized receipt stating: patient name, name of practitioner, type of practitioner, date of service, charge for treatment, date last paid by provincial plan (if applicable), and licence and/or registration number.							

Patient Name (First and Last)	Relationship	Date of Birth			Type of Expense ie. Drugs, Vision, Practitioner, etc.	Total Charge
		Day	Mo	Yr		

PLEASE PROVIDE NAME OF SCHOOL IF THE PATIENT IS A STUDENT 21 YEARS OR OLDER:

Is this claim on yourself or your dependent(s) for a work related accident or sickness?	YES	NO
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CO-ORDINATION OF BENEFITS	Are you, your spouse or dependents covered under any other plan for the expenses being claimed?	YES	NO
	If you answered "yes" to other coverage please provide the following information:		
Name of Family Member Insured:	Birthdate (Yr/ Mo/ Day)		
Relationship to Employee:	Name of Insurance Company:		

I authorize release of any information or record requested in respect of this claim to **ALTERNATIVE BENEFIT SOLUTIONS INC.** and certify that the information given is true, correct and complete to the best of my knowledge. Personal information we collect from you will be used to determine your entitlement to benefits under this plan.

SIGNATURE OF EMPLOYEE _____ DATE _____

Please allow for sufficient mailing time and 5 business days for claims processing.