Reset Form

Print Form

# Extended Health Care Claim Form

*groupSource*
Suite 400, 1550 - 5th Street SW
Calgary, AB T2R 1K3

## Employee Information

| | | |
|---|---|---|
| Policy Number | Employer Name | Employee Identification Number |
| Last Name / Given Name / Name Commonly Used | | Gender ☐ Male ☐ Female |
| Apt. / House # | Street Address | Date of Birth yyyy / mm / dd |
| City / Province / Postal Code | | Daytime Tel. No./Evening Tel. No. |

## Spouse and Children Covered by this Claim

Complete only if claim includes expenses for spouse or children.

1. If you are claiming for your **spouse**, complete the following:

Last Name / Given Name / Name Commonly Used / Date of Birth yyyy / mm / dd / Gender ☐ Male ☐ Female

Is your spouse covered for any of these expenses under any medical plan or contract? ☐ No ☐ Yes If yes, you should submit the claim to your spouse's plan first. When your spouse's plan is also through *groupSource*, benefits can be coordinated efficiently if both claim forms are completed and submitted together.

2. If you are claiming for your **children**, complete the following:

| Last Name / Given Name / Name Commonly Used | Relationship to Employee: Son | Daughter | Date of Birth: yyyy | mm | dd |
|---|---|---|---|---|---|
| | ☐ | ☐ | | | |
| | ☐ | ☐ | | | |
| | ☐ | ☐ | | | |
| | ☐ | ☐ | | | |

*If child is over 22, supporting documents from the school are required.

Are your children covered for any of these expenses under your spouse's medical plan or contract? ☐ No ☐ Yes If Yes, what is the month and day of your spouse's birthday? Month: _____ Day: _____ Your children must claim first under the plan of the parent with the earliest birthday (month and day). Please see note 2 on the back of this form.

## Details of Claim

Attach Original Receipts **OR** If this claim has been submitted under another plan, attach the original Explanation of Benefits from that plan **and** copies of the receipts.

1. Are the expenses the result of an accident? ☐ No ☐ Yes

If yes, where did the accident occur? ☐ Work ☐ Home ☐ Other When did the accident occur? yyyy / mm / dd

Are any expenses the result of a condition covered by Workers' Compensation? ☐ No ☐ Yes

2. Fill in the total of all receipts for each category. ***If this claim is for services incurred Out-of-Country, contact *groupSource* for the appropriate form.**

| | |
|---|---|
| Prescription Drugs<br>**IMPORTANT:** If any prescription receipt is $100 or more, please indicate the number of days the prescription will last: _____ days | $ |
| Other (Please specify e.g. "paramedical services" etc.) | $ |
| | $ ***Total Amount Claimed*** |

**Assignment of Benefits (complete only if payment to be issued directly to the service provider)**

I hereby assign any benefits payable for eligible paramedical services, medical supplies or prescriptions provided by: _____ and authorize direct payment to the provider indicated on the attached invoices.

Employee Signature Sign printed form Date Signed Date printed form

## Employee Signature

### Authorization and Declaration

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 the insurer, 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 dependents for such purposes. **Any copy of this Authorization and Declaration shall be as valid as the original.**

Employee Signature Sign printed form Date Date printed form

**Please note: Original signature is required on each claim form.**

| Date Employed | Date Covered | Date Dependent Covered | Date Terminated | Retirement Date |
|---|---|---|---|---|
| | | | | |

*groupSource* is committed to protecting the confidentiality, accuracy and security of the personal information it collects and uses in the course of conducting business.

# How to Claim
# Extended Health Care Benefits

**Before completing the form...**

1. If you are claiming expenses for your spouse who is covered under another medical plan, submit the claim for your spouse's expenses to your spouse's plan first. Please include a copy of what the other plan paid when claiming your spouse's expenses on your plan.

2. If both you and your spouse have medical coverage, expenses for your children must be claimed under the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 1st and your spouse's birthday is June 5th, your children's expenses will be claimed under your plan first.

3. You do not have to submit a claim every time an expense occurs. You may hold your expense receipts until they represent a significant amount, or are more than your deductible, if applicable. You should keep in mind that there is a deadline for submitting your expense receipts to *groupSource*. To find out what the deadline is, look in your employee booklet or talk to your employer. If your Extended Health Care coverage ends for any reason, your claim for expenses incurred while coverage is in place must be submitted to and received by *groupSource* within 90 days of your coverage ending.

**After completing the form...**

4. Please make sure that you have filled in all the information completely and signed the form. Incomplete forms will delay the processing of your claim.

5. Attach **original** receipts for expenses and keep copies for your records. Original receipts will not be returned. You will receive an Explanation of Benefits for income tax purposes. If any expense has been submitted previously under another plan, attach the original Explanation of Benefits from that plan and copies of the receipts. Your receipts should include the name of the patient, the nature of the treatment or medical product, the name of the prescribing physician, the date, and the amount charged.

6. Attach a written statement from the referring doctor if you are claiming for certain medical services or expenses such as medical equipment, nursing services, or massage therapy. The written statement should confirm why the services were medically necessary and how long the services were needed. If the expenses were the result of a dental accident, X-rays taken after the accident and before any treatment are required.

**Mail forms to...**

***groupSource***
Suite 400, 1550 - 5th Street SW
Calgary, AB T2R 1K3

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