MEDAVIE BLUE CROSS™

HEALTH SPENDING ACCOUNT/ PERSONAL WELLNESS ACCOUNT

MEMBER INFORMATION

ID Number: _____ Policy Number: _____

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ○ Yes ○ No If yes, signature of member is required for validation: _____

OTHER COVERAGE

Do you or any dependents have coverage under any other plan?

○ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

○ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ○ **Individual** ○ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ○ Hospital ○ Travel ○ Extended Health ○ Drugs ○ Vision ○ Dental ○ **All**

HEALTH SPENDING ACCOUNT / PERSONAL WELLNESS ACCOUNT SELECTION

All eligible services will be assessed under your base plan.

Do you want this claim processed through your Health Spending Account? ○ Yes ○ No

Do you want this claim processed through your Personal Wellness Account? ○ Yes ○ No

CLAIM INFORMATION

	CLAIMANT'S NAME		RELATIONSHIP TO MEMBER Self, Spouse, Child	DATE OF BIRTH			TYPE OF SERVICE	DATE OF SERVICE			AMOUNT PAID
	First Name	Last Name		day	month	year		day	month	year	
1											
2											
3											
4											
5											
6											
										TOTAL CLAIM AMOUNT	

MEMBER STATEMENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

MEMBER Signature _____ Date _____

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces
PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Quebec
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

Ontario
PO Box 2000 STN A
Etobicoke ON M9C 5P1
Inquiries: 1-800-667-4511

Other Provinces and Territories
PO Box 2318 STN Main
Edmonton AB T5J OL8
Inquiries: 1-800-667-4511

*** Please ensure all areas are complete. Incomplete information may delay processing.**
*** Please attach all original paid-in-full receipts or an EOB from the primary carrier and photocopies of receipts.**
*** Prescription drug receipts must indicate: name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.**
*** Original receipts will not be returned.**
*** All receipts should indicate: name of supplier/provider, item/service rendered, provider telephone number.**