

**MEMBER INFORMATION**

ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Provincial Health Plan Number (only applicable to BC and SK residents): \_\_\_\_\_

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

**CLAIM INFORMATION**

	Claimant's Name		Relationship to Member Self, Spouse, Child	Date of Birth			Type of Service E.g. Physiotherapy; diabetic supplies; eye glasses; etc.	Date of Service			Amount Paid	Apply unpaid balance to HSA (check for each expense)	
	First Name	Last Name		day	month	year		day	month	year		YES	NO
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
<b>TOTAL CLAIM AMOUNT</b>													

**MEMBER STATEMENT**

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by my Blue Cross plan may be collected, used, or disclosed to administer and manage the terms of my plan of which I am an eligible member or dependent, to recommend suitable products and services to me, and to manage my Blue Cross plan's business. For the purposes listed above, limited personal information may be collected from and /or released to a third party. This third party may include another Blue Cross organization, a licensed physician, health care professional or institution, life and health insurer, government and regulatory authorities, the member of any plan under which I am a dependent or another third party.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent my Blue Cross plan from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. **I authorize my Blue Cross plan to collect, use and disclose my personal information as described above.**

All medical expenses must be claimed through your provincial and group insurance plans before payment can be made from a Health Spending Account. I confirm that benefits under this plan, any government program or alternate group plan (i.e. spouse's/partner's coverage) have been accessed.

**I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.** If claiming expenses for an uninsured dependent under your Health/Dental contract, I, the undersigned, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

MEMBER Signature \_\_\_\_\_ Date \_\_\_\_\_

This consent complies with federal and provincial privacy laws. For additional information regarding your Blue Cross plan's privacy policies, call 1-888-873-9200.

**ADDRESSES**

<b>Atlantic Canada</b> PO Box 220 644 Main St Moncton NB E1C 8L3	<b>Quebec</b> 1981 McGill College Ave, Suite 100 PO Box 3300, Postal Station B Montreal QC H3B 4Y5	<b>Ontario</b> PO Box 2000 185 The West Mall, Suite 1200 Etobicoke ON M9C 5P1	<b>Manitoba</b> PO Box 1046 Winnipeg MB R3C 2X7	<b>Saskatchewan</b> PO Box 4030 516 2nd Avenue N Saskatoon SK S7K 3T2	<b>Alberta</b> PO Box 2318 STN Main Edmonton AB T5J 0L8	<b>British Columbia</b> PO Box 7000 Vancouver BC V6B 4E1
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\* Each plan is an independent licensee of the Canadian Association of Blue Cross Plans.

**INQUIRIES: 1-888-873-9200**

\* 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.