Equitable Life of Canada®

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SUPPLEMENTARY MEDICAL BENEFITS CLAIM FORM

PLAN MEMBER'S LAST NAME		GIVEN NAMES	NAME OF EMPLOYER	
ADDRESS		APT.	POLICY NUMBER	DIVISION (IF APPLICABLE)
CITY	PROV.	POSTAL CODE	CERTIFICATE/I.D. NUMBER	DATE OF BIRTH

DRUG EXPENSES

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd / mm / yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	❑ ❑ ❑		❑	❑		$
	❑ ❑ ❑		❑	❑		$
	❑ ❑ ❑		❑	❑		$
	❑ ❑ ❑		❑	❑		$
	❑ ❑ ❑		❑	❑		$
	❑ ❑ ❑		❑	❑		$

OTHER EXPENSE (Excluding Drugs)

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd / mm / yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Amount Charged For Each Expense	Date of Visit or Purchase (dd / mm / yyyy)	Type of Expense
	❑ ❑ ❑		❑	❑		$		
	❑ ❑ ❑		❑	❑		$		
	❑ ❑ ❑		❑	❑		$		
	❑ ❑ ❑		❑	❑		$		
	❑ ❑ ❑		❑	❑		$		
TOTAL OF ALL DRUG AND OTHER	➤	➤	➤	➤	➤	**$**		

If you have a Health Care Spending Account (HCSA) please complete the following.

To ensure you maximize your benefit coverage, review any coverage you have through any provincial health insurance or private plan and claim accordingly. A private plan may include benefit coverage you and/or your dependents have through another insurance carrier. You may find it useful to review the Coordination of Benefits provisions in your Plan Member booklet/brochure.

Please select one of the following options:

❑ I want my eligible expenses paid from my Equitable Life health or dental plan ONLY

❑ I want my eligible expenses paid from my Equitable Life health or dental plan FIRST and my unpaid portions of my eligible expenses paid from my HCSA.

❑ I want ALL my eligible expenses paid directly from my HCSA

Please note:
If you do not select any of the above options, no portion of this claim will be paid from your Health Care Spending Account (HCSA)

PLEASE COMPLETE AND SIGN REVERSE SIDE →

Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

1. Are medical benefits also provided through another Group Insurance Plan? Yes ❑ No ❑

If "Yes" complete the following information about the person who is the member under the other plan.

MEMBER'S NAME	CERT/I.D. NUMBER	DATE OF BIRTH
INSURANCE COMPANY'S NAME		POLICY PLAN #

If the health coverage under another group insurance plan has been cancelled, please give cancellation date _____/_____/_____
day month year

If the Group Insurance Plan mentioned in this question is an Equitable Life plan and inforce, do you want us to co-ordinate benefits? Yes ❑ No ❑

2. Are claims being submitted as a result of an accident? Yes ❑ No ❑ If "Yes" give date, location and explain how accident happened.

_____

_____

3. Are any expenses related to an illness/injury that is work related? Yes ❑ No ❑

Attach all original receipts (photocopies or carbon copies are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc.

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

Plan Member Signature _____ Date _____

Falsifying or tampering with claim documents / receipts could have legal consequences.