

Healthcare/Visioncare Claim Statement

Instructions: Attach the bills and receipts for all expenses and itemize them by providing all the information requested. Note: All bills and receipts are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes. **Please answer all questions.** This claim will be returned to you if it is incomplete or contains errors.

Employees Last & First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mmm/dd/yyyy)	Policy/Group #:
Employee HOME Mailing Address	Employer/ COMPANY Name		Employee/Cert #:
	Email:		
	Work Ph.	Home Ph.	

• Are you or your dependents entitled to receive comparable benefits from any other insuring company? Yes No

If yes, complete the following:

• Does your spouse work for the same employer? Yes No

If yes, indicate his/her name: _____ Identification No: _____

• Are you or your dependent(s) entitled to benefits under any other group insurance plan? Yes No

If yes, indicate name of other group insurer _____ Policy No: _____ Name of Family Member Insured _____

• Is treatment required as the result of an accident? Yes No

• If yes, give date, location, and explain how accident happened _____

• Is claim being made for Workers Compensation Benefits? Yes No

• If patient is a dependent child, please provide spouse's date of birth (mmm/dd/yyyy) ____/____/____

Please separate all eligible expenses by claimant and attach original receipts

Please **add** all expenses together for **each** member submitting claims on this form
All dental expenses must be submitted using a standard dental claim form provided by your practitioner

NAME OF PATIENT	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (MMM/DD/YYYY)	CLAIM DETAILS			
			# OF RECEIPTS	DRUG EXPENSES	# OF RECEIPTS	MEDICAL/VISION EXPENSES
TOTAL CHARGE				\$		\$

I authorize any portion of the claimed item(s) not paid by my health plan to be reimbursed from my **Health Spending Account**.

Protecting your personal information: At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Name of Employee (Please Print)	Signature of Employee	Date
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 ProBenefits Inc. <small>employer benefit solutions</small>	PBI OFFICE USE ONLY
	Cheque #:
	Date:
	Cheque Amount:

SUBMIT CLAIMS TO: Mail: #8 4402 37 Street Stony Plain AB T7Z 2A9 E-mail: claims@probenefitsinc.ca	CONTACT US: Ph. 780 963 5230 Toll Free. 800 375 3360 Fax. 780 963 0982
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