ProBenefits Inc.
employer benefit solutions

#8 4402 37 Street
Stony Plain AB, T7Z 2A9
Phone: 1 800 375 3360
www.probenefitsinc.ca

Health &/or Vision Claim Form

All sections of this form must be completed in FULL or it could result in a delay of claim.

Section 1: Personal Information

This claim will be delayed or returned to you if it is incomplete or contains errors. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims. Payment provided through a Private Health Services plan. The Income Tax Act provides guidelines as to what benefits are allowed under this plan type.

Employer/Company Name:			Group Policy #:
Employee First & Last Name:			Certificate/ID #:
Employee Address:	City:	Province:	Postal Code:
Email:			Phone:

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.

Employee Signature:	Date:

Section 2: Coordination of Benefits

Are you or your dependents entitled to receive comparable benefits from any other insuring company? ○ YES ○ NO

If you answered **YES**, please complete the following:	Name of other insurer:	Policy #:
Name of family member insured:		Identification/Certificate #:

Section 3: WCB/Accident Claim

Is a claim being made for Workers Compensation Board (WCB)? ○ YES ○ NO

Is treatment required the result of an accident? ○ YES ○ NO If YES, please explain:

Section 4: HCSA Authorization

○ Check here if you want any eligible unpaid portion topped up by your HealthCare Spending Account (HCSA)

Section 5: Claim Information

List names of persons you are claiming expenses for, add up receipts and enter the **TOTAL** amount claimed per person.

NAME OF PATIENT	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (MMM/DD/YYYY)	CLAIM DETAILS			
			# OF RECEIPTS	HEALTH/VISION EXPENSES	# OF RECEIPTS	DENTAL EXPENSES
		TOTAL		**$**		**$**
		COMBINED MEDICAL/DENTAL TOTAL	**$**			

NOTE: You should consult your independent tax advisor to review the eligibility of claims according to CCRA guidelines. ProBenefits assumes no responsibility for financial maximums that exceed the allowable amount by the Income Tax Act.

SUBMIT CLAIMS TO:
Mail: #8 4402 37 Street Stony Plain, AB, T7Z 2A9
E-mail: claims@probenefitsinc.ca

ProBenefits Inc. OFFICE USE ONLY
Cheque/EFT #:
Date:
Amount: