MEDICAL AND DRUG EXPENSES CLAIM

Forward claims to: THE BENEFITS TRUST

3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9 Phone: 905-264-8990, 1-800-487-2993

Your Name: ______________________ Your Certificate Number: ______________

Address: ______________________ Apt/Unit: ________

City: ______________ Province: ______________ Postal Code: __________

Employer: ______________________ Group / Policy Number: ______________

Claims Section

List all prescriptions and/or items purchased. Please attach ORIGINAL receipts for every expense.
Attach your physician's written recommendation and diagnosis where applicable.

Name of Patient	Birth Date	Relationship To Employee	Date of Medical Expense	Name of Drug or Type of Purchase	Drug Identification No. (DIN)	Amount Charged

Refer to your benefits booklet or ask your employer to confirm who is considered an eligible dependant.
Submit Overage Dependant form if not already on file.

TOTAL __________

Coordination of Benefits

Is this medical care covered by any other group insurance? Yes ☐ No ☐ If Yes, Name of Insured: ______________

Name of Insurance Company: ______________________ Policy Number: ______________

Health Care Spending Account

(Expenses must be eligible under the Income Tax Act)

Do you want any part of this claim to be paid through your Health Care Spending Account? Yes ☐ No ☐

If Yes:
1) Please attach original receipts, or if expenses have been submitted under this or another plan and you are now claiming for the unpaid portion, please attach copies of the receipts, and the Explanation of Benefits from the previous submission.
2) Please indicate whether you want: All of the remaining portion of the claim to be paid ☐ or A specific amount ☐ $ __________

I hereby certify that the above information is true to the best of my knowledge and that these expenses were incurred by myself (or my dependants) for the exclusive use of the person for whom the expense was incurred, as indicated above. I authorize The Benefits Trust and its administrators to use my social insurance number for identification purposes in the handling of my claim. In addition, I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. A photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Signature of Covered Employee: ______________________ **Date:** ______________