CDCS HEALTH CLAIMS INC.

HEALTH CLAIM FORM

Co-ordination of benefits provision – please read NOTES above questions 2 and 3 before completing form.

- Attach **original** accounts/receipts to back of form. **Photostats, carbon copies, credit card receipts or cash register receipts** are not acceptable.
- For drug claims, prescription number and name of drug or D.I.N. (Drug Identification Number) must be shown on all receipts.
- Receipts will be destroyed on payment of your claim, unless they are not eligible for payment or you have requested them to be returned.
- Claims must be submitted within 180 days after the calendar year in which the charge was incurred.
- Incorrect or incomplete information will delay payment.

Employee's Statement (refer to your group certificate) – Please print

Policy/Plan no.	Div. no.	Certificate	Employees Initials

Employee's date of birth Day Month Year	Policyholder/Company name

1. If claim is for a child age 21 or 22 (based on policy) or over, indicate: ❑ Handicapped ❑ Student — If student, then name of school or university

NOTE: Under the Co-ordination of benefits provision, if your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan.

2. Do you have coverage under any other plan? (e.g. spouse's employer, Worker's Compensation, etc.) ❑ No ❑ Yes, complete the following

Insuring agency	Policy no.	Certificate no.

NOTE: Charges for dependent children should first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year (excluding the year of birth).

3. If claim is for dependent child, indicate: Name of spouse: / Spouse's date of birth (day, month)

4. If claim is for out-of province/out-of-country charges, please indicate: Departure date (day, month, year) Return date (day, month, year)

5. If claim is for out-of-province/out-of-country charges are any of the submitted expenses covered under any other travel insurance policy (e.g. Blue Cross, Voyageur, credit card insurance?) ❑ No ❑ Yes, complete the following:

Policy no.	Certificate no.	Insurance agency

Please indicate total charges separately for each patient (one line only per person). Eligible Charges refers to Visioncare, hospital, ambulance, paramedical, etc., if applicable to your plan.

Full name of patient	Relationship to employee	Date of birth Day	Month	Year	Total DRUG Charges	Total Charges OTHER Than Drug
				Totals		

I authorize the release of any information requested in respect of this claim to the Insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge. I consent to the use of my Social Insurance Number and any claim information for the administration of the benefits under this group policy.

Date (day, month, year) Signature of Employee

Return Address – Please print – correspondence will be returned to the employee or provider, depending on the address completed below.

Name

Address (number, street, city, province, postal code)

Send complete form to the appropriate claims office below:

MAILING ADDRESS: P. O. BOX 156, STATION "B", SUDBURY, ON P3E 4N5 WWW.CDCS.CA TEL (705) 675-2222
STREET ADDRESS: 58 LISGAR ST., SUITE 300, SUDBURY, ON P3E 3L7 FAX (705) 675-2376 TOLL FREE 1-800-265-2327