Extended Health Benefit Claim Form

Affinity Markets Health Claims
Manulife Financial
PO Box 4214, Stn A
Toronto ON M5W 5M4

Manulife Financial

PLEASE REFER TO REVERSE SIDE PRIOR TO COMPLETION OF THIS FORM.
PLEASE PRINT CLEARLY

COMPLETE AS SHOWN ON YOUR CERTIFICATE

Plan No.	Identification No.	Plan Name

Plan Member

Address	City or Town	Province	Postal Code

Home Telephone No.: ( ) Business Telephone No.: ( )

NAME(S) OF PERSON(S) FOR WHOM BENEFITS ARE BEING CLAIMED

	NAME	DATE OF BIRTH DAY	MO.	YEAR	SEX M	F
Plan Member						
Spouse						
Dependant Child						
Dependant Child						
Dependant Child						
Overage Dependant*						
	Total Amount Claimed	$				

OVERAGE EDUCATION VERIFICATION (Must be completed & updated each new term for all dependant children over 21 years - see reverse*)

NAME OF DEPENDANT	NAME OF UNIVERSITY OR ACCREDITED INSTITUTE OF LEARNING	FROM: (MO./YR.)	TO: (MO./YR.)

1) Is this a Workplace Safety and Insurance Board case (W.S.I.B.)? Yes ❑ No ❑

2) Is your claim a result of an accident? Yes ❑ No ❑

If answer is "Yes" to questions 1 or 2 above, give explanation including a brief description of illness or injury and where and when injury occurred: _____

_____

_____

Do you or your dependants have coverage for these benefits under another plan? Yes ❑ (see reverse)** No ❑

If "Yes", complete the following: Policy/Plan No.: _____ Agreement/I.D. No.: _____

Name and address of insurance company/organization: _____

AUTHORIZATION

I/We hereby certify that the information provided in connection with this claim is true, accurate and complete. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my/our health or the health of any insured member of my/our family as it may relate to this claim to release such information to Manulife Financial to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

_____ _____

Plan Member Signature Date

Manulife Financial

PROCEDURE FOR MAKING A CLAIM

Receipts must be on the printed letterhead of the person or company providing the service and must clearly show:

- name of patient
- description of service
- date(s) of service
- cost of each service rendered

NOTE: Original receipts (**Not Photocopies**) must accompany this claim form. Please keep a copy of your receipt(s) for your records, originals will not be returned.

INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR CLAIM

CLAIMING PRESCRIPTION DRUGS?

Receipts must show the:

- name of the drug
- drug identification number (DIN)
- prescription number
- strength
- quantity

CLAIMING PROSTHETIC APPLIANCES AND DURABLE MEDICAL EQUIPMENT?

Claims for prosthetic appliances and durable medical equipment must be accompanied by the original receipt and written authorization from the attending physician, indicating the diagnosis.

***CLAIMING OVERAGE DEPENDANTS?**

If your Plan covers dependant children over the age of 21 years who are in full-time attendance at a university or accredited institute of learning, please ensure that the **Education Verification** Section (on reverse side) is completed. This section must be completed and updated each new school term.

****COORDINATION OF BENEFITS**

A plan member's claim should always be submitted to his or her own insurance carrier first. Any remaining eligible expenses will then be paid by the spouse's insurance carrier.

Claims for dependant children should first be submitted to the plan of the parent whose month and day of birth come earliest in the calendar year. Any remaining **eligible** expenses will then be paid by the spouse's carrier.

CLAIM SUBMISSION AND INQUIRIES

- **CLAIM SUBMISSION SHOULD BE DIRECTED TO:**

AFFINITY MARKETS, HEALTH CLAIMS
PO BOX 4214, STN A
TORONTO ON M5W 5M4

- **FOR ALL INQUIRIES PLEASE CALL:**

1-800-COVER ME ®
(1-800-268-3763)

OR: www.coverme.com