claimsecure

HEALTH CLAIM FORM

Plan Member's Full Name:	Group or Employer	Personal Identification No.
	Air Canada	Group # 002152 I.D.#
		Date of Birth Day / Month / Year

Plan Member's Address

Street _____ Apt. _____

City _____

Province _____ Postal Code _____

Language Preference
☐ English
☐ French

Telephone No. _____

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth Day	Month	Year	Relationship to Plan Member
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyy)	Recommended by: Physician's name	Amount

Total Claim $

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? ☐ Yes ☐ No

2 b. Name of other insuring agency or plan _____

2 a. If yes, indicate member under other plan: ☐ Self ☐ Spouse

Policy No. _____ Certificate No. _____

Name _____ Date of Birth Day Month Year

N.B. **For coordination of benefits**, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

Health Services Spending Account / Wellness Account Signature

I wish any portion of my claim not paid by my Extended Health plan to be reimbursed from my: ☐ Health Services Spending Account ☐ Wellness Account
I hereby certify that the above expenses are considered eligible by Revenue Canada to be payable from a Health Services Spending Account.

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Date _____ **Plan Member's Signature** _____

All information recorded on this form is confidential

Send all claims and inquiries to:

AIR CANADA / CLAIMSECURE INC.
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