IAMAW/AC Employee Assistance Program
Counseling Confidential Statement of Claim for Active Employees

claimsecure

INSTRUCTIONS: COPY OF YOUR RECEIPT MUST BE ATTACHED FOR EACH EXPENSE AND FULLY ITEMIZED IN THE SPACE PROVIDED BELOW. **NOTE**: RECEIPTS, OTHER THAN THOSE REQUIRED FOR GOVERNMENT DRUG PLANS ARE PART OF OUR RECORDS AND WILL NOT BE RETURNED. THE ITEMIZATION OF EXPENSES THAT WILL ACCOMPANY OUR CHEQUE OR EXPLANATION OF BENEFITS SHOULD BE RETAINED FOR YOUR RECORDS AND FOR INCOME TAX PURPOSES.

Send documents, using a special pre-addressed blue coloured envelope (ACF851N (2007-10)) which is sent by company mail, to Group Health and Dental Insurance Administration, Air Canada Centre 1001.

IMPORTANT: IF ANY OF THE REQUESTED INFORMATION IS MISSING OR INCOMPLETE, THIS CLAIM MAY BE RETURNED. PLEASE COMPLETE A SEPARATE FORM FOR EACH FAMILY MEMBER FOR WHOM YOU ARE CLAIMING EXPENSES. 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.

PLEASE PRINT:

PART 1. CLAIM INFORMATION

PROVIDER OF SERVICE	TYPE OF SERVICE	DATE OF SERVICE	CHARGE	NATURE OF ILLNES

PART 2. EMPLOYEE INFORMATION

PLAN NO. 9368 EMPLOYEE IDENTIFICATION NO. _____

NAME OF EMPLOYER AIR CANADA

EMPLOYEE NAME _____ DATE OF BIRTH: ____/____/____ (DAY / MONTH / YEAR)

EMPLOYEE ADDRESS _____

"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."

EMPLOYEE'S SIGNATURE _____ DATE: _____

PART 3. PATIENT INFORMATION

1. PATIENT'S NAME _____ 2. PATIENT'S RELATIONSHIP TO EMPLOYEE _____

3. PATIENT'S DATE OF BIRTH: ____/____/____ (DAY / MONTH / YEAR) 4. IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU? ☐ YES ☐ NO

5. IF THE PATIENT IS A CHILD OVER 18: A) IS HE/SHE A FULL-TIME STUDENT? ☐ YES ☐ NO IF YES, HOW MANY HOURS PER WEEK?
B) IS HE/SHE EMPLOYED? ☐ YES ☐ NO IF YES, HOW MANY HOURS WORKED PER WEEK?

6. IF PATIENT IS OTHER THAN EMPLOYEE 'S SPOUSE OR CHILD, IS EMPLOYEE ENTITLED TO CLAIM A PERSON CREDIT UNDER THE INCOME TAX ACT (CANADA) IN RESPECT OF THE PATIENT? ☐ YES ☐ NO

7. A) ARE YOU OR ANY OTHER MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS FROM ANY OTHER SOURCE? ☐ YES ☐ NO

IF YES, NAME AND ADDRESS OF OTHER SOURCE _____

NAME OF FAMILY MEMBER INSURED _____ POLICY NUMBER _____

B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? ☐ YES ☐ NO

IF YES, NAME OF FAMILY MEMBER _____

C) IF YES TO QUESTION 7 A) OR B), AND THE PATIENT IS A DEPENDENT CHILD, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ____/____/____ (DAY / MONTH)

ClaimSecure Inc.
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