Chambers of Commerce Group Insurance Plan®

Please print your Firm & Certificate #

Firm #	Certificate #

E X T E N D E D H E A L T H C L A I M

INSTRUCTIONS (Please read carefully)

We need your original receipts, **OR** the Explanation of Benefit statement and copies of receipts from any plan that has already paid a portion of the expense, to process your claim. Please staple your receipts or statement with copies to this form. **We do not return original receipts.**

Receipts must include the service date; a complete breakdown of charges; and the practitioner's name, credentials, address, and phone number.

Before mailing this form, make sure all questions on this form are answered. If you send an incomplete form, your claim may take longer to process.

Expenses paid by your group benefit plan are not eligible income tax deductions. You may be eligible to claim any amounts not covered by the Plan. Your Explanation of Benefits will be accepted as proof of amounts not covered by the Plan.

EMPLOYEE INFORMATION

Firm Name ______________________________

Employee's Full Name ______________________________

Home Mailing Address ______________________________
Apartment/Street City / Town Province Postal Code

Please provide a phone number where we can reach you during the day if we have any questions about your claim. (____) ______________

Patient's Name	Birthday M/D/Y	Relation to Employee	Service Type	Total Amount Charged/Patient
			Total	

CO-ORDINATION OF BENEFITS

Are you claiming for a dependent child who is age 21 or older? ❑ No ❑ Yes

Child is ❑ physically/mentally handicapped (medical evidence may be requested) ______________

❑ a student enrolled full time at (school's name) ______________

Are you or your dependents entitled to health benefits under any other plan? ❑ No ❑ Yes If "Yes," family member insured ______________

Name of insuring company ______________ Spouse's birthdate ______________ M/D/Y

ACCIDENT INFORMATION

Are any of the services provided as a result of an accident? ❑ No ❑ Yes If "Yes," enclose a brief description of the date and details of the accident.

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the benefit plan.

I certify that the answers to the above questions are full and true to the best of my knowledge and that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I authorize Chambers Plan, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Chambers Plan and its insurance companies to exchange information when necessary to assess my claim and to administer the group benefit plan. A photocopy of this authorization is as valid as the original when obtaining information.

Employee's Signature ______________________________ Date ______________

ALL INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL

Please mail this completed form and your original receipts to

Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1 1-800-665-3365

Insuring Company: Desjardins Financial Security