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)

Drug Claims must be accompanied by original receipts issued by the pharmacy. Photocopies are not acceptable.

Hospital Claims must be accompanied by a fully completed hospital claim form.

Claims for Registered Massage Therapist services must include a referral from your Physician for ongoing services. If you have been treatment-free for six months or longer and require these services again, we need a current referral letter. (This Plan does not cover any charges for the completion of a form.)

No reimbursement will be made under this benefit for services, treatment or supplies provided to the Employee by the Employer.

Claims must be accompanied by a fully itemized account showing the diagnosis, dates of treatment, details of treatment and a complete breakdown of charges. Receipts must show practitioner's designation, address, and phone number. **All the information you provide on this form will be treated as confidential.**

Complete Firm Name _____

Employee's Full Name Mr./Mrs./Ms./Miss _____

Home Mailing Address _____

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

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

1. Are you or your dependents entitled to benefits under any other plan? ❑ Yes ❑ No
   If "Yes," family member insured _____
   Policy No. _____
   Name and address of insuring company
   _____
   _____
   _____

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

3. Are you claiming for a dependent child who is age 21 or older? ❑ Yes ❑ No
   If "Yes," child's name _____
   Child is ❑ physically/mentally handicapped
   ❑ a student enrolled **full time** at (school's name)
   _____

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. I hereby authorize and request my Physician or Surgeon to furnish any information required in connection with this claim. A photocopy of this authorization is as valid as the original.

Employee's Signature _____ Date _____

Expenses paid by your Group Insurance 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. ***We do not return original receipts.***

Patient's Name	Birthday M D Y	Relation to Employee	Service Type	Drug Name	Service Date M D Y	Amount
					Total	

EHC-PDF-03-05

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