BENEFIT CLAIM STATEMENT

Submit Claims to:

6 Cumberland Street
Barrie, ON L4N 2P4
Phone (705) 734-6279
Fax (705) 734-9725
Toll Free Phone (800) 661-9023

Payment provided through Private Health Services Plan. Please note the Income Tax Act provides guidelines as to what benefits are allowed under this type of plan.

Employee Last Name	Employee First Name	Middle Initial	Date of Birth (M/D/Y)

Employer Name	Employee Street Address, City, Province , Postal Code	Phone Number

Reimburse the Provider (i.e. Dentist etc.)? Yes No (if yes, please ensure to provide full name and address)

Dentist Name	Address

Please separate all eligible expenses by claimant and attach eligible receipts:

Name of Patient	Relationship to Employee	Date of Birth	**Health Charges**	**Vision Charges**	**Dental Charges**
		Total:			

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN REPSECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. THE CLAIM INFORMATION WILLINGLY PROVIDED BY ME TO SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. HELD IN THEIR FILE WILL BE USED BY SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. FOR THE PURPOSES OF CLAIMS PROCESSING AND ADJUDICATION. I UNDERSTAND AND AUTHORIZE THAT FOR THE ABOVE PURPOSES THE PERSONAL INFORMATION ON FILE IS ACCESSIBLE TO, AND MAY BE EXCHANGED WITH, AUTHORIZED EMPLOYEES OF AND RELEVANT THIRD PARTIES RETAINED BY SKIPWITH & ASSOCIATES INSURANCE AGENCY INC., ITS SALES DISTRIBUTION NETWORK, PARTICIPATING RE-INSURER (S), OTHER INSURANCE COMPANIES, INVESTIGATIVE ORGANIZATIONS, HEALTH CARE PROVIDERS, INCLUDING, BUT NOT LIMITED TO, PHARMACIES, PYSICIANS, DENTISTS, AND ANY OTHER PERSON OR PARTY WHOM I AUTHORIZE. IF APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION LSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES. I UNDERSTAND THAT CLAIMS MADE UNDER THE GROUP POLICY ARE SUBMITED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. TO EXCHANGE INFORMATION ABOUT THESE CLAIMS WITH ME OR ANY PERSON ACTING ON MY BEHALF, INCLUDING A SPOUSE OR DEPENDENT, AS DEEMED NECESSARY FOR THE PURPOSE OF CONFIRMING ELIGIBILITY AND ASSESSING AND MANAGING THE CLAIM.

_____ ___
SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

_____
DATE (DD/MM/YYYY)