SUBMIT TO:

SKIPWITH & ASSOCIATES INSURANCE AGENCY INC.
6 CUMBERLAND STREET, BARRIE, ON L4N 2P4
Phone (705) 734-6279
Toll Free (800) 661-9023
Fax (705) 734-9725

HEALTH CARE CLAIM FORM

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors

NOTE: Attach all original receipts (photocopies or carbon copies are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc. If you need additional space attach a second form.

PART 1: EMPLOYEE / PLAN MEMBER / SUBSCRIBER INFORMATION

EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE SURNAME	GIVEN NAME

ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE

PART 2: EMPLOYER INFORMATION

PLAN NUMBER	DIVISION NO.	NAME OF EMPLOYER

ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE

PART 3: CO-ORDINATION OF BENEFITS AND OTHER DETAILS

1. Are you or any other member of your family entitled to benefits under any other plan?	❑ **Yes**	❑ **No**
If "Yes", provide name of family member insured:		
Relationship to employee:		
Name of other insurance company: Policy No:		
2. Is any member of your family (other than yourself) insured as an employee under this plan?	❑ **Yes**	❑ **No**
If you have answered yes to question 1 or 2 please provide your spouse's date of birth: (M/D/Y)		
3. Are claims being submitted as a result of an accident?	❑ **Yes**	❑ **No**
If "Yes" give date, location and brief explanation of how the accident happened:		
4. Are any expenses related to an illness / injury that is work related?	❑ **Yes**	❑ **No**
5. Would you like any unpaid balance to be reimbursed from your Health Spending Account /Cost Plus Account (If Applicable)?	❑ **Yes**	❑ **No**

PART 4: PRESCRIPTION DRUG DETAILS

Patient Name	Relationship to Employee	Date of Birth (M/D/Y)	Is child a fulltime student or disabled?	No. of Receipts Per Patient	Total Drug Amount Charged Per Patient

PART 5: OTHER HEALTH EXPENSES

Patient Name	Relationship to Employee	Date of Birth (M/D/Y)	Is child a fulltime student of disabled?	Type of Expense	Amount Charged	Date of Visit or Purchase

PART 6: AUTHORIZATION & SIGNATURE

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.

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SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER DATE (DD/MM/YYYY)