

## MEMBER INFORMATION

ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth (DD/MM/YYYY): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Daytime Telephone No.: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

Has your mailing address changed since your last claim?  Yes  No If yes, signature of member is required for validation: \_\_\_\_\_

## OTHER COVERAGE

Do you or any of your dependents have other coverage under any other plan?  Yes  No

**If Yes, complete the following:**

Name of other Insurer: \_\_\_\_\_ Member Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

**Please indicate type of coverage (✓):**  Hospital  Extended Health  Dental  Eye Wear  Drugs  Travel  All

## CLAIM INFORMATION

Claimant's Name	Relationship to Member Self, Spouse, Child	Date of Birth			Type of Service E.g. Physiotherapy; diabetic supplies; eye glasses; etc.	Date of Service			Amount Paid	Apply unpaid balance to HSA (check for each expense)		
		day	month	year		day	month	year		YES	NO	
Eg ED	SMITH	Self	01	05	1980	Drugs	01	10	2007	\$35.00	X	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
<b>TOTAL CLAIM AMOUNT</b>												

## EMPLOYEE STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me\*, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. **I authorize my Blue Cross plans to collect, use and disclose my personal information as described above.**

The Canada Revenue Agency (CRA) requires that all medical expenses be claimed through your provincial and group insurance plans before payment can be made from a Health Spending Account. I confirm that benefits under this plan, any government program or alternate group plan (i.e. spouse's/partner's coverage) have been accessed.

**I, the undersigned, accept full responsibility that all expenses incurred and submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Federal Income Tax Act.** If claiming expenses for an uninsured dependent under your Health/Dental contract, I, the undersigned, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

EMPLOYEE Signature \_\_\_\_\_ Date \_\_\_\_\_

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit [www.medavie.bluecross.ca](http://www.medavie.bluecross.ca) or call 1-800-667-4511. \*applicable in Atlantic Canada

### MEDAVIE BLUE CROSS ADDRESSES

**New Brunswick and Prince Edward Island**  
644 Main St PO Box 220  
Moncton NB E1C 8L3  
Inquiries: 1-800-667-4511

**Nova Scotia**  
7 Spectacle Lake Dr Dartmouth  
PO Box 2200 Halifax NS B3J 3C6  
Inquiries: 1-800-667-4511

**Newfoundland and Labrador**  
66 Kenmount Road, Suite 102  
Kenmount Business Centre  
St. John's NL A1B 3V7  
Inquiries: 1-800-667-4511

**Ontario**  
185 The West Mall Suite 1200  
Etobicoke ON M9C 5P1  
Inquiries: 1-800-355-9133

\* Please ensure all areas are complete.  
\* Please attach all original paid-in-full receipts; if receipts were submitted under another plan and the unpaid portion is now being claimed, please attach copies of your receipts along with the original "Explanation of Benefits" statement from the other insurer.  
\* Prescription drug receipts must indicate: name; strength and quantity of drug; drug identification number (DIN); prescription number (RX); patient's name.