GroupHEALTH Benefit Solutions

CLAIM FORM - MEDICAL EXPENSES

claimsecure

Group#	Certificate/ID#
Company Name	
Member Surname	First Name
Date of Birth(day/month/year)	Preferred Language ☐ English ☐ French

Member's Address Apt #	Street# and Name	
City	Province	Postal Code
Phone# Home	Work	
Cell Phone	Email	

MEDICAL EXPENSES (Attach original receipts for expenses listed below; do NOT staple or tape receipts to the claim form) Please print

Name (member or insured dependent)	Relationship to Member	Date of Birth			Total
		day	month	year	
1)					$
2)					$
3)					$
4)					$
5)					$
6)					$
7)					$
8)					$
9)					$
10)					$
11)					$
				Total	$

Please check the box if any of the above expenses are for Hospital Indemnity. ☐

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purpose of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement for the above charges and explanation of such amounts paid will be provided to the benefit plan member.

I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Date: _____ Member's Signature: _____

Please send claim form to: CLAIMSECURE INC. PO BOX 2444 SUDBURY, ON P3E 0G7