ONTARIO BLUE CROSS™

Extended Health Care Benefit Claim Form

NAME

ADDRESS

CITY PROV. POSTAL CODE

NAME OF PARTICIPANT	POLICY NUMBER / CONTRACT NUMBER	ID / GROUP NUMBER

* PLEASE FILL OUT THIS FORM AND ENCLOSE ORIGINAL COPIES OF YOUR BILLS AND RECEIPTS. **THESE DOCUMENTS WILL NOT BE RETURNED. DUPLICATES SHOULD BE RETAINED FOR YOUR FILE.**

ARE EXPENSES SUBMITTED COVERED BY ANY OTHER INSURANCE CONTRACT? ☐ YES ☐ NO

IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ☐ YES ☐ NO

IF YES: _____ _____

CONTRACT NUMBER INSURER'S NAME

N.B. : THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT HIS CLAIM TO HIS INSURER. AFTERWARDS, PROVIDE BLUE CROSS WITH A COPY OF YOUR RECEIPTS WITH A DETAILED ACCOUNT OF BENEFITS PAID. FURTHERMORE, CLAIMS FOR CHILDREN MUST BE SUBMITTED TO THE INSURER OF THE PARENT (FATHER OR MOTHER) WHOSE BIRTHDAY OCCURS FIRST IN THE CALENDAR YEAR.

I CERTIFY THAT THE EXPENSES SUBMITTED WERE INCURRED FOLLOWING AN ILLNESS OR AN INJURY AND THAT MY STATEMENTS ARE TRUE AND COMPLETE. FURTHERMORE, I AUTHORIZE BLUE CROSS TO OBTAIN FROM THE MEDICAL PRACTITIONER AND / OR MEDICAL CENTRE ALL PERTINENT INFORMATION RELEVANT TO THIS CLAIM.

DATE SIGNATURE TELEPHONE NUMBER

ONTARIO BLUE CROSS™

P.O. BOX 4433
STATION A
TORONTO, ONTARIO
M5W 3Y7

IF YOU ARE CLAIMING FOR A DEPENDENT CHILD (AGED 18 OR 21 AND OVER BUT UNDER 25) PLEASE PROVIDE THE FOLLOWING INFORMATION:

GIVEN NAME	NAME OF SCHOOL, COLLEGE OR UNIVERSITY BEING ATTENDED	SEMESTER	FULL TIME	PART TIME

* PLEASE INDICATE THE TOTAL AMOUNT SUBMITTED FOR EACH PATIENT, PER CALENDAR YEAR.

GIVEN NAME	DATE OF BIRTH D	M	Y	SEX	RELATIONSHIP	AMOUNT SUBMITTED	CALENDAR YEAR	**FOR BLUE CROSS USE ONLY**
TOTAL						$0.00		

NOTE: FOR CONVENIENCE, THE MASCULINE GENDER USED IN THIS DOCUMENT ALSO INCLUDES THE FEMININE GENDER.