HEALTHCARE EXPENSES STATEMENT

INSTRUCTION: Attach the bills and original receipts for all expenses and itemize them by providing all the information requested. Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax Purposes.

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

Please Print

PART 1: EMPLOYEE'S STATEMENT					
PLAN NUMBER	DIVISION NO.	PLAN NAME			
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME			
ADDRESS: NUMBER AND STREET	**TOWN**	**PROVINCE**	**POSTAL CODE**	**PHONE NUMBER**	
				HOME:	**WORK:**

COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan?

☐ Yes ☐ No

If "Yes", name of family member insured _____

Relationship to employee _____

Name of other insurance company _____

Policy Number _____

Is any member of your family (other than yourself) insured as an employee under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's Date of birth _____/_____.
Day Month

SEND THIS CLAIM TO

CV Benefits Inc
734 – 13 Street N
Lethbridge, Alberta T1H 2T1

DEPENDENT INFORMATION					If child over 18 years	
Patient Name	***Relationship To Employee***	***Birthdate***			***Full Time Student***	***Name of School/College/University***
		Yr	***Mo***	***Day***	***Yes ___ No ___***	
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	

CLAIM DETAILS	**DRUG EXPENSES**		**OTHER EXPENSES**		
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

I authorize release of any information or record requested in respect of this claim to ***your company*** and certify that the information given is true, correct and complete to the best of my knowledge. Personal information we collect from you will be used to determine your entitlement to benefits under this plan.

SIGNATURE OF EMPLOYEE _____ DATE _____