

HEALTHCARE CLAIM FORM

EMPLOYEE STATEMENT				
Group Contract Number	Certificate N	umber		
Employee Last name and given name	name Date of birth (MM/DD/YY)			
Employee Address:				
WOULD YOU LIKE YOUR CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT? YESD, I have included a void cheque.				
Please note that only a one time void cheque is required. If you change your banking information, a new void cheque will be needed. COORDINATION OF BENEFITS				
1. Does your spouse and/or children have coverage under any other medical plan or contract? Yes No				
If yes, spouse's date of birth? (MM/DD/YY)				
Insurance company, policy number and certificate number				
2. Is any expense the result of an accident? I Yes No				
If yes, Date of accident Location of accident Work 🛛 Home 🖛 Other 🗅				
Explain how the accident occurred				
3. If this claim is for a child 21 years of age or older, please indicate the following: Is the child handicapped I Is the child a full time student I DRUGS, VISION CARE, PARAMEDICAL SERVICES AND OTHERS – PATIENT INFORMATION				
	Date of birth			II
Patient's name (Use one line per patient)	Month Day Year	Relationship to plan member	Total charge	REMINDER
				PLEASE REFER TO YOUR
				EMPLOYEE SUMMARY OF BENEFITS TO CONFIRM THE
				AMOUNT OF TIME YOU HAVE TO SUBMIT A CLAIM.
				THIS FORM MUST BE
				COMPLETED IN FULL. INCOMPLETE FORMS WILL
				BE RETURNED TO YOU,
PRESCRIPTION DRUGS				WHICH WILL DELAY THE PROCESSING OF THE CLAIM.
PRESCRIPTION DRUGS TOTAL FEE SUBMITTED Please attach your original receipts to the back of this form.				
All drug receipts must contain the drug identification and the name of the prescription drug.				
VISION CARE – ASSIGNMENT OF BENEFITS				
Name and address of provider: I hereby assign my benefits payable from this claim to the named provider				
ж.		authorize payments directly to him/her.		
PRC				
Telephone: AUTHORIZATION		Signature of employee		Date
I, the undersigned, authorize the Cowan Insurance Group ("CIG"), my employer, my plan administrator, physician, health care professional, hospital,				
medical facility, insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with CIG, or its representatives, all medical or				
benefit payment information or any other information or records in its possession that CIG may hold or request for the purposes of adjudicating this				
claim.				
I certify that the information I am submitting in support of my claim is true and complete to the best of my knowledge and belief. I understand that				
CIG may investigate my claim by collecting additional relevant personal information about me or my dependents from me and/or from other third				
parties. In cases of suspected fraud or plan abuse, CIG will investigate and I agree that CIG may share information with regulatory bodies, government or police agencies, healthcare professionals and the plan administrator or employer, if appropriate.				
l agree that a photocopy of this authorization shall be as valid as the original.				
Date: Member signature:				
MAIL YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:				
Cowan Insurance Group 700-1420 Blair Place Ottawa, Ontario K1J 9L8				
Telephone: 1-888-509-7797 or 1-613-741-3313				