



Plan Member's Full Name:	Group or Employer	Personal Identification No.	
		Group #	I.D.#
		Date of Birth Day / Month / Year	

Plan Member's Address	Street _____ Apt. _____	Language Preference	
	City _____	<input type="checkbox"/> English	
	Province _____ Postal Code _____	<input type="checkbox"/> French	
		Telephone No. _____	

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth			Relationship to Plan Member
	Day	Month	Year	
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Nature of expense	Date incurred (dd/mm/yyyy)	Recommended by: Physician's name	Amount

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	2 b. Name of other insuring agency or plan _____ _____	Total Claim \$
2 a. If yes, indicate member under other plan: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	Policy No. _____ Certificate No. _____	
Name _____ Date of Birth _____ <div style="display: flex; justify-content: space-around;"> Day Month Year </div>		

*** Note: Do NOT staple or tape receipts to the claim form ***

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 purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of 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 _____ Plan Member's Signature _____

All information recorded on this form is confidential
 Send all claims and inquiries to:
CLAIMSECURE INC.
 PO BOX 6500 STN A SUDBURY ON P3A 5N5 1-888-513-4464