EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS

Part 1 - EMPLOYEE INFORMATION - This section MUST be completed in full by the employee.

Employer Name: _____ _____

Employee Name: _____

Employee Address: _____

Box No./Apt. No., Number and Street

_____ _____ _____

City or Town Province Postal Code

EMPLOYEE I.D. NO FROM YOUR ASSURE™ CARD

(Carrier) (Policy No.) (Certificate No.) (Issue No.)

Equitable Life of Canada®

Please submit completed form to:
Emergis Inc.
Claims Payment Department
5090 Explorer Drive, Suite 1000
Mississauga, Ontario L4W 4X6

Is this a Health Care Spending Account claim? ❑ Yes ❑ No

Is this claim an adjustment to a previously paid claim? ❑Yes ❑ No

If Yes, please have your Benefit Administrator authorize:_____

Part 2 - CLAIMANT INFORMATION - THIS SECTION MUST LIST **ALL** CLAIMANT INFORMATION.

IMPORTANT - Original pharmacy receipts **MUST** be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee = 01; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

Part 3 - OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of School: _____

Address of School: _____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 - CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' Compensation Board or Government Plan? ❑ Yes ❑ No

If yes, please advise us of the name of the other insuring agency or plan: _____

Group Policy/Plan No.: _____ Cert./I.D. No.: _____

Spouse's day and month of birth: Day _____ Month _____

If this claim has been submitted under another plan, you **MUST** attach the original Explanation of Benefits statement from that plan and the **COPIES** of the receipts.

Part 5 - OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made? _____

What is the currency of this country? _____

I certify that the information provided above by me is true, correct and complete to the best of my knowledge. I understand that the purpose of this information is to seek reimbursement from my insurer for the medication identified in the attached pharmacy receipt(s). I authorize my insurer and their authorized representatives to review the information provided on this form and any attachments for the purpose of determining reimbursement. I acknowledge that Emergis Inc. is acting as an authorized representative of my insurer.

EMPLOYEE SIGNATURE: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU. PLEASE KEEP A COPY FOR YOUR RECORDS. ALL INQUIRIES MUST BE MADE THROUGH YOUR EMPLOYEE BENEFIT OFFICE OR INSURANCE COMPANY.