

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**

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(Carrier)

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(Policy No.)

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(Certificate No.)

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(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.