HealthSource Plus
Group Benefits • Administration • Wellness • Retirement

Claim for Group Health Benefits

HSP Form No. 3b
01.1

A. Employee/Employer Information

Employer's Name:	Policy N$^{o.}$:	Certificate N$^{o.}$:

		Sex	Birth Date		
Employee's Last Name:			D	M	Y
Employee's First Name:		☐ M ☐ F			

Mailing Address ____
Street , Suite N$^{o.}$: City Province Postal Code

Language: ☐ English ☐ French

DO YOU WANT ANY UNPAID BALANCE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH SERVICE SPENDING ACCOUNT - HSSA (IF ELIGIBLE)? ☐ **YES** ☐ **NO**

B. Claim Information

Please complete all requested information and list expenses in date order. Use a separate line for each person and **attach original receipts**.
Incomplete forms or photocopied receipts cannot be processed for payment.

Patient's Name	Relationship to Employee	Birth Date			Is Dependent child full time student?	Receipt date			Description of Expense	Total Charge
		D	M	Y		D	M	Y		
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					
					☐ Yes* ☐ No					

***If child is 22 or over and registered as a full time student, please indicate the school name and the most recent date of registration**

Dependent Last Name, First Name	Name of School	D	M	Y

C. Coordination of Benefits

1. Are any of these expenses related to a Workers' Compensation Claim? ☐ Yes ☐ No
2. Are benefits available from another group plan? ☐ Yes ☐ No
   If yes, please provide the Insurance Carrier Name:
   Policy N$^{o.}$:
3. If other coverage was available and has recently terminated, please provide termination date: Day _________ Month ______________Year _________

The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Health Source Plus with a completed form and a copy of the settlement provided by the other carrier.
Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.

Employee Authorization

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 understand that Health Source Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds
I authorize ClaimSecure, Health Source Plus, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure and Health Source Plus to exchange necessary information regarding this claim to administer my health benefit plan.

Name (Please Print) Signature Date Signed (dd/mm/yyyy)

Submit Form To: **ClaimSecure Inc.**
P.O. Box 7000 Station A
Sudbury, ON P3A 6E5

Claims Inquiries: Tel.: 1-888-513-4464