

A. Employee/Employer Information

Employer's Name:		Policy N ^o :	Certificate N ^o :				
Employee's Last Name:				Sex	Birth Date		
Employee's First Name:				<input type="checkbox"/> M <input type="checkbox"/> F	D	M	Y
Mailing Address	Street, Suite N ^o :		City	Province	Postal Code		
Language: <input type="checkbox"/> English <input type="checkbox"/> 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? <input type="checkbox"/> Yes* <input type="checkbox"/> No	Receipt date			Description of Expense	Total Charge
		D	M	Y		D	M	Y		
					<input type="checkbox"/> Yes* <input type="checkbox"/> No					
					<input type="checkbox"/> Yes* <input type="checkbox"/> No					
					<input type="checkbox"/> Yes* <input type="checkbox"/> No					
					<input type="checkbox"/> Yes* <input type="checkbox"/> No					
					<input type="checkbox"/> Yes* <input type="checkbox"/> No					
					<input type="checkbox"/> Yes* <input type="checkbox"/> 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)
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Submit Form To: ClaimSecure Inc.
P.O. Box 7000 Station A
Sudbury, ON P3A 6E5

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