HEALTHCARE CLAIM FORM

You may fill out the form online and print it or print the form and fill it out by hand.

EMPLOYEE STATEMENT

Group Contract Number ___________________ Certificate Number ___________________

Employer ___________________

Employee Last name and given name ___________________

Date of Birth : day ________ / month ________ /year ________ Sex F ☐ M ☐

Employee Address: ___________________

WOULD YOU LIKE YOUR CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT? Yes☐, I am attaching a void cheque in order to benefit from that service. Once you have provided a void cheque, only send another void cheque if you change your bank information.

COORDINATION OF BENEFITS

1. Does your spouse and/or children have coverage under any other medical plan or contract? ☐ Yes ☐ No
   If yes, please complete the following:
   Spouse's date of birth (D/M/Y) ___________________
   Insurance company, policy number and certificate number ___________________

2. Is any expense the result of an accident? ☐ Yes ☐ No
   If yes, please complete the following: Date ___________________ Location of accident Work ☐ Home ☐ Other ☐
   Explain how the accident occurred ___________________

3. If this claim is for a child 21 years of age or older, please indicate the following:
   Is the child handicapped ☐
   Is the child a full time student ☐

DRUGS, VISION CARE, PARAMEDICAL SERVICES AND OTHERS – PATIENT INFORMATION

Patient's name (Use one line per patient)	Date of birth			Relationship to plan member	Total charge
	Day	Month	Year		
				TOTAL FEE SUBMITTED	$0.00

REMINDER

PLEASE REFER TO YOUR EMPLOYEE SUMMARY OF BENEFITS TO CONFIRM THE AMOUNT OF TIME YOU HAVE TO SUBMIT A CLAIM.

THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE RETURNED TO YOU, WHICH WILL DELAY THE PROCESSING OF THE CLAIM.

PRESCRIPTION DRUGS

Please attach your original receipts to the back of this form. All drug receipts must contain the drug identification and the name of the prescription drug.

VISION CARE – ASSIGNMENT OF BENEFITS

PROVIDER

Name and address of provider:

Telephone:

I hereby assign my benefits payable from this claim to the named provider and authorize payments directly to him/her.

____
Signature of employee Date

AUTHORIZATION

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my certificate number as an identification number where it is required in the administration of my group benefit plan. I authorize Cowan, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Cowan to exchange information when necessary to assess my claim and to administer the group benefit plan.

I certify that the information given is true, correct and complete to the best of my knowledge.

Signature of employee ___________________ **Date** ___________________

MAIL YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:

Cowan Insurance Group
700-1420 Blair Place
Ottawa, Ontario K1J 9L8
Telephone: 1-888-509-7797 or 1-613-741-3313