RTO/ERO Group Benefits Program
Régime collectif d'avantages sociaux d'ERO/RTO
ADMINISTERED BY / ADMINISTRÉ PAR Johnson Inc.

CLAIM FORM

Extended Health Care • Out-of-Province/Country

A) MEMBER INFORMATION

Policyholder: **Certificate Number:**

Name (First, Last): _____
Address: _____
_____
_____
Email Address: _____

Use Direct Deposit? Yes ☐ No ☐
If you would like your reimbursement deposited directly to your bank account, please enclose a "void" cheque.

B) CLAIM INFORMATION

Number of receipts attached: _____ **Total Amount claimed:** $ _____

1) Is claim the result of a Dental Accident? Yes ☐ No ☐

2) Is claim the result of an emergency that occurred while traveling outside province of residence? Yes ☐ No ☐

If you have answered YES to either questions 1 or 2, please attach dates and details separately.

C) DEPENDENT INFORMATION (INCLUDING SPOUSE)

Name (First, Last)	Birth Date	Relationship	Gender	Student*	School Year

* Dependents age 21 and over are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of this school year, the upper limit of the dependent definition age for students or until coverage is terminated. Proof of full-time status may be required at any time.

D) CO-ORDINATION OF BENEFITS

With Co-ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level, single/couple//family, the spouse/dependent may have with another insurance provider.

Name of Family Member: _____ **Coverage:** _____

Name of Family Member: _____ **Coverage:** _____

I authorize Johnson Inc., Plan Administrator, to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Johnson Inc., will be kept confidential and, where necessary Johnson Inc. will be exchanging personal information. I authorize the following persons to exchange with Johnson Inc. or each other, any of my personal information in their possession; any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution. I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Member Signature: _____ **Date Signed:** _____

Please mail completed claim form and receipts to:

Johnson Inc., Plan Benefits, Claims
1595-16th Avenue
Suite 700
Richmond Hill Ontario L4B3S5
1-800-638-4753 (toll free)
905-764-4888

Johnson Inc.
Insurance • Benefits • Administration