EXTENDED HEALTH BENEFITS CLAIM FORM

ALL OF THE FIELDS IN THIS BOX MUST BE COMPLETED.
ATTACH **ORIGINAL** BILLS, RECEIPTS, STATEMENTS ETC. COPIES WILL BE DENIED AND THE CLAIM WILL BE RETURNED.

GROUP NO.	DIVISION NO.	CERTIFICATE NO.	NAME OF EMPLOYER

INSURED'S NAME	DATE OF BIRTH M D Y
INSURED'S ADDRESS: (APARTMENT NO., STREET NAME, P.O. BOX AND/OR R.R.#)	PHONE NUMBER

CITY	PROVINCE	POSTAL CODE	EMAIL ADDRESS

Has your employment terminated? ☐ Yes ☐ No If Yes, Date_____

Is claim being made for Worker's Compensations Benefits? ☐ Yes ☐ No

If treatment was required because of an accident, how did the accident happen?	Date of Accident M D Y	Time ☐ AM ☐ PM	Where did it happen? ☐ At work ☐ At home ☐ Elsewhere

Have you, your spouse or dependent children any other Extended Health Insurance coverage, under which the expenses being claimed are eligible? ☐ Yes ☐ No

If yes, Name of Policyholder _____ Group Number _____ Certificate Number _____ Spouse's date of Birth

Name of other Insurance Company _____ (M/D/Y)_____

NOTE: Photocopies of receipts will be allowed for Co-Ordination of Benefit (COB) claims. You must also attach the original "Explanation of Benefits" from your alternate carrier.

Some Group Plans may have elected to include the Incidental Health Expense Benefit (IHE) as an optional component to their Extended Health Benefits. If your plan does not include this option, please disregard the IHE questions, and complete the remainder of the form.

All of this Claim to be Paid Through IHE ☐ **YES** ☐ **NO**

CLAIM SUMMARY

Patient Name	Date of Purchases or Services Rendered	Name of Drug or Type of Service	Charge	Balance Paid Through IHE
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

I certify that the statements above are complete and true and that all attached receipts represent no duplication of charges previously submitted.

I authorize:

1. The relevant physicians, hospitals and other service providers to release full information and records with respect to this claim to The Empire Life Insurance Company (Empire Life) and I authorize Empire Life, its agents, representatives or consultants to collect and review this information (as deemed necessary) for the purpose of reviewing, assessing and managing this claim;
2. Empire Life to release to the policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management;
3. Empire Life to reimburse the insured plan member directly with respect to this claim.

I agree a photocopy of this authorization shall be as valid as the original.
I understand all claims made under this Group Plan are submitted through the insured plan member. Empire Life may exchange information about these claims with the insured plan member or any person acting on his or her behalf (as deemed necessary) for the purpose of confirming eligibility and assessing and managing the claim.

Date: _____ Signature of Claimant:_____

SEE REVERSE FOR MORE INFORMATION

In order to obtain prompt payment of your claim, did you…

Provide a void cheque to receive claim payments via EFT (Electronic Funds Transfer)?
Complete and sign your claim form?
Include your correct current address and postal code?
Include original receipts?
Include a copy of the Explanation of Benefits from your other insurance company if co-ordinating benefits?

Empire Life reserves the right to ask for additional information in order to assess this or any future claims.
Payment of this claim does not indicate that all future claims for these items or services will be approved.

Claims submitted more than 365 days of the date of service or more than 90 days after termination of coverage will be declined as too late to allow.

When Completed, Please Mail Your Claim Form To:

The Empire Life Insurance Company
Group Health Claims
259 King Street East
Kingston ON
K7L 3A8

Missing or incorrect information results in unavoidable delays in claims payment.

Insurance Fraud
Insurance Fraud is an intentional act or omission with a view to illegally obtaining an insurance benefit.
Fraudulent claims increase the cost of your group insurance.

Group Customer Service Unit 1-800-267-0215