MEDICAL EXPENSE CLAIM FORM

Print Form

COUGHLIN
employee benefits specialists

Mailing Address:
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P.O. Box 3517, Station C
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ottclaims@coughlin.ca
www.coughlin.ca

Plan member - insured

Group or employer: Personal identification #:

Full name: Language preference: Date of birth (y/m/d):

Address: City: Province: Postal code:

Home telephone #: Work telephone #: ext.:

Are any health benefits or services provided under any other group insurance or health plan, workers' compensation or government plan?

◯ Yes ◯ No If YES, who is the member of this other plan?

Name: Date of birth (y/m/d): Relationship to plan member:

Name of other insuring agency or plan: Policy #: Certificate #:

Dependants

Please complete this section if you are claiming an expense for a dependant.
For co-ordination of benefits, children must claim under the plan of the parent whose birthday occurs earlier in the calendar year.

Full name: Date of birth (y/m/d): Relationship:

Complete this section, if dependant is age 21 or over. Name of School: Current or most recent registration period:

Full name: Date of birth (y/m/d): Relationship:

Complete this section, if dependant is age 21 or over. Name of School: Current or most recent registration period:

Full name: Date of birth (y/m/d): Relationship:

Complete this section, if dependant is age 21 or over. Name of School: Current or most recent registration period:

☐ Drug Expenses

Attach original receipts containing the drug identification number (DIN) and name of the drug.

☐ Vision Care Expenses

Attach original itemized receipts. Date of final payment:

Is this a new prescription? ◯ Yes ◯ No If NOT, reason for replacement

Check one

◯ Single ◯ Bifocal
◯ Contact lenses ◯ Trifocal

Check one *(if applicable)*

◯ Occupational safety glasses
◯ Prescription sunglasses
◯ As a result of cataract surgery *(attach physician's recommendation)*

Cost of lens(es)
Cost of frame(s)
Examination fee *(if applicable)*
Other *(please explain)*
Total charges

☐ Other Expenses

Attach original itemized receipts. *For equipment and appliance expenses, Coughlin & Associates Ltd. requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).*

Nature of expense: Date incurred: Recommended by: Amount:

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I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. **I certify** that the information given is true, correct and complete to the best of my knowledge.

Date (y/m/d): Signature:

Protecting your personal information The administrator of your group benefits plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.