The EQUITABLE LIFE insurance company
OF CANADA
One Westmount Road North • PO Box 1603 Stn Waterloo
Waterloo Ontario N2J 4C7 tel. no: (519) 886-5110

SUPPLEMENTARY MEDICAL BENEFITS CLAIM FORM

INSURED'S LAST NAME	GIVEN NAMES		NAME OF EMPLOYER	
ADDRESS	APT.		POLICY NUMBER	DIVISION (IF APPLICABLE)
CITY	PROV.	POSTAL CODE	CERTIFICATE/I.D. NUMBER	DATE OF BIRTH

1. Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

2. Are medical benefits also provided through another Group Insurance Plan? Yes ❑ No ❑

If "Yes" complete the following information about the person who is the member under the other plan.

Member's Name _____ Cert/I.D# _____ Date of Birth_____/_____/_____
day month year

Insurance Company's Name _____ Policy Plan # _____

If the health coverage under another group insurance plan has been cancelled, please give cancellation date _____/_____/_____.
day month year

If the Group Insurance Plan mentioned in this question is an Equitable Life plan and inforce, do you want us to co-ordinate benefits? Yes ❑ No ❑

3. Are claims being submitted as a result of an accident? Yes ❑ No ❑ If "Yes" give date, location and explain how accident happened.

_____

_____

4. Are any expenses related to an illness/injury that is work related? Yes ❑ No ❑

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize.
If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my bhealf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

Employee's Signature _____ *Date* _____

Falsifying or tampering with claim documents / receipts could have legal consequences.

Attach all original receipts (photocopies or carbon copies are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc.

DRUG EXPENSES

Patient's Usual Name	Relationship to Plan Member			Date of Birth			Children only; check if:		Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	Self	Spouse	Child	dd	mm	yyyy	full-time university or college student	disabled		
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$
	❑	❑	❑				❑	❑		$

OTHER EXPENSES (Excluding Drugs)

Patient's Usual Name	Relationship to Plan Member			Date of Birth			Children only; check if:		Type of Expense	Amount Charged for Each Expense	Date of Visit or Purchase			Practitioner's or Supplier's Name
	Self	Spouse	Child	dd	mm	yyyy	full-time university or college student	disabled			dd	mm	yyyy	
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
	❑	❑	❑				❑	❑		$				
TOTAL OF ALL DRUG AND OTHER EXPENSES ➤ ➤ ➤ ➤ ➤ ➤ ➤ ➤ ➤										$				