Seventh-day Adventist Church in Canada
Post-Retirement Benefits Health and Dental Claims Form

How to Make Your Claim

- Use this form to submit claims for reimbursement of all medical expenses and services.
- Attach the original receipt for each expense claimed and keep photocopies for your records.
- Sign on page 2 and mail your claim to the address at the bottom of page 2.

Please print clearly and be sure all sections are complete to avoid delays in processing your claim.

1. RETIREE INFORMATION					
Last name:	First name:			Middle:	
Date of birth (yyyy-mm-dd):				Sex: ❑ M ❑ F	
Street address:				Home phone no.:	
City:	Province:			Postal Code:	

2. COMPLETE THIS SECTION IF YOU OR YOUR SPOUSE ARE COVERED UNDER ANOTHER PLAN					
Who is a member of another benefit plan?*	❑ You			❑ Spouse	
Type of coverage	❑ Single			❑ Family	
Are you claiming any expenses that are not covered under your spouse's plan?	❑ Yes – if yes, please specify:			❑ No	
Spouse's signature: **X**	Date (yyyy-mm-dd):				
Any other Medical Benefits for Retiree, Spouse or Patient?	❑ Yes – if yes, please select option below:			❑ No	
	❑ Blue Cross	❑ Provincial Plan	❑ Employer Plan	❑ Other	Policy #:

* If you have coverage through your spouse, send your claims to the Church's Health Allowance plan first. When you receive your claim statement, send it and copies of your receipts to your spouse's plan for adjudication of any unpaid claims. Your spouse's claims must be sent to his or her plan for consideration before adjudication under the Health Allowance plan.
* To use your HCSA to claim for the unpaid amount, attach the claim statement(s) you received to your claim form.
* Refer to the Coordination of Benefits information in your Post Retirement Benefits Plan booklet for additional information on coordinating coverage with your spouse's or other benefit plans.

3. INFORMATION ABOUT YOUR CLAIM

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed. Please remember to include all receipts and claim statements from other insurers with this form when submitting your claim.

Person for whom you are making the claim (Last name, First Name)	**Date of Birth** (yyyy-mm-dd)	**Relationship to you**	**Full-time student**	**Disabled**	**Amount claimed**
			❑ Yes ❑ No	❑ Yes ❑ No	$
			❑ Yes ❑ No	❑ Yes ❑ No	$
			❑ Yes ❑ No	❑ Yes ❑ No	$
				Total Amount Claimed	$

Seventh-day Adventist Church in Canada
Post-Retirement Benefits Health and Dental Claims Form

3. INFORMATION ABOUT YOUR CLAIM (cont.)

Are you attaching receipts for out-of-Canada expenses? ❑ Yes ❑ No If yes, tell us the date of departure from the claimant's home province. Ensure the currency and amounts are clearly marked on each receipt.	Departure date (yyyy-mm-dd):	Out-of-Canada expenses claimed: $
Are any of the expenses you're claiming the result of a motor vehicle accident? If yes, did you submit your claim to the automobile insurance plan in your province, if applicable?		❑ Yes ❑ No ❑ Yes ❑ No
Are any of the expenses you're claiming the result of any other accident? ❑ Yes ❑ No	Date of accident (yyyy-mm-dd):	

4. AUTHORIZATION AND SIGNATURE

I certify that all goods and services being claimed have been received by me and/or my spouse or dependants, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse and/or dependants, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims.

I authorize Health Allowance Administrator to use and exchange information about me, and if applicable, my spouse and/or dependants needed for underwriting, administration and adjudicating claims under this plan with any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this plan is audited.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations.

If I am making a claim under my Health Care Spending Account (HCSA), I certify that these expenses qualify for reimbursement I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependants as defined under the Health Care Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. I also understand that my plan sponsor may have access to a summary of the total amounts claimed by me under my Health Care Spending Account for the purposes of tax or administrative reporting.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this plan.

Signature: **X**	Date (yyyy-mm-dd):

Note that in some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

Send your completed form, along with your receipt(s) to the address below.

Health Benefits Administration
1148 King Street East
Oshawa, ON L1H 1H8