claimsecure

MAJOR MEDICAL EXPENSES STATEMENT

BURMAN UNIVERSITY

Plan Member's Full Name	Group or Employer	Personal Identification No.
	BURMAN UNIVERSITY	Group # **550002** Student ID # **BUSS**
		Date of Birth Day / Month / Year

Plan Member's Address

Street _____ Apt. _____

City _____

Province _____ Postal Code _____

Language Preference
❑ English
❑ French

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth			Relationship to Plan Member	If this claim is for a dependent child aged 21 or over, please indicate the most recent date on which the child was registered as a full-time student			
	Day	Month	Year		Name of School	Day	Month	Year
				Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____				
				Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____				
				Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____				
				Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____				

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Nature of expense	Date incurred	Recommended by: Physician's name	Amount

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? ❑ Yes ❑ No

2 a. If yes, indicate member under other plan:
❑ Self ❑ Spouse

2 b. Name of other insuring agency or plan _____

Policy No. _____ Certificate No. _____

Total Claim $

Name _____ Date of Birth Day Month Year

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.
I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Date _____ **Plan Member's Signature** _____

All information recorded on this form is confidential.
Send all claims and inquiries to:

CLAIMSECURE PO BOX 6500 STN A SUDBURY ON P3A 5N5
1-888-513-4464