



MAJOR MEDICAL EXPENSES STATEMENT



Plan Member's Full Name	Group or Employer Northern Ontario School of Medicine University Student Council	Personal Identification No. Group # 514563 Student ID # SOM
	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 b. Name of other insuring agency or plan _____		Total Claim \$
2 a. If yes, indicate member under other plan: ☐ Self ☐ Spouse		Policy No. _____ Certificate No. _____		
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