



MAJOR MEDICAL EXPENSES STATEMENT



Plan Member's Full Name	Group or Employer FANSHAWE COLLEGE	Personal Identification No.
		Group # 514560 I.D.R.
		Date of Birth Day / Month / Year

Street _____ Apt. _____ English
 French
City _____
Province _____ Postal Code _____

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 member qualified as a full-time student			
	Day	Month	Year		Name of School	Day	Month	Year
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input checked="" type="checkbox"/> Other (describe) _____				
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____				
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (describe) _____				
				Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	2 b. Name of other insuring agency or plan _____	Total Claim \$												
2 a. If yes, indicate member under other plan: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	Policy No. _____ Certificate No. _____													
Name _____ Date of Birth <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Day</td><td>Month</td><td>Year</td><td> </td><td> </td><td> </td></tr></table>							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.	
Day	Month	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 _____

All information recorded on this form is confidential.
Send all claims and inquiries to:
ClaimSecure Inc.
43 Elm Street, Suite 200, Sudbury, Ontario P3C 1S4
1-888-513-4464