ONTARIO BLUE CROSS®

CLAIM FORM
Extended Health Care Benefit

IDENTIFICATION

Last name	First name	
Address		
No. / Street		Apt.
City	Province	Postal Code

PARTICIPANT IDENTIFICATION

Name of participant	Contract No.	Certificate No.

*** Please fill out this form and enclose original copies of your bills and receipts. These documents will not be returned. Duplicates should be retained for your file.**

INFORMATION

Were expenses incurred following an accident? ☐ Yes ☐ No	If yes, please specify
Date (DD-MM-YYYY)	Location
Circumstances	
Are the expenses submitted covered under any other insurance contract? ☐ Yes ☐ No	
Is your spouse covered under another health insurance contract? ☐ Yes ☐ No ☐ Not applicable	
If yes, please specify:	
Contract No.	Insurer's name

N.B.: The spouse who is covered by another health insurance plan must first submit a claim to his/her insurer. Afterwards, provide Ontario Blue Cross with a copy of the receipts with detailed account of benefits paid. Claims for children must be submitted to the insurer of the parent (father or mother) whose birthday occurs first in the calendar year.

STATEMENT

I certify that the expenses submitted were incurred following an illness or an accident and that my statements are true and complete. Furthermore, I authorize Ontario Blue Cross to obtain from the medical practitioner and/or medical centre all pertinent information relevant to this claim.

Signature of insured	Date (DD-MM-YYYY)	Telephone No.

SEND TO THE FOLLOWING ADDRESS:
Ontario Blue Cross
PO BOX 4433, Station A
Toronto, ON M5W 3Y7

Please provide information on medical expenses on the back of this form.

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DEPENDENT CHILD INFORMATION

If you are claiming for a dependent child (aged over 18 or 21 [according to the contract] but under 25) please confirm his/her student status:

Given name	Name of school, college or university attended	Semester	Full time	Part time
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PLEASE INDICATE THE TOTAL AMOUNT SUBMITTED FOR EACH PATIENT, IN CHRONOLOGICAL ORDER.

Given name	Date of birth			Sex	Relationship	Amount submitted	Date of purchase (DD-MM-YYYY)	For Blue Cross use only
	Day	Month	Year					
					TOTAL	$0.00		