

**EXTENDED HEALTH CLAIM**

**Employee Information**

Firm Name \_\_\_\_\_

Employee's Full Name \_\_\_\_\_

Home Mailing Address \_\_\_\_\_  
Apartment/Street City / Town Province Postal Code

Please provide a phone number where we can reach you during the day if we have any questions about your claim. (\_\_\_\_\_) \_\_\_\_\_

Patient's Name	Birthday M/D/Y	Relation to Employee	Service Type	Total Amount Charged/Patient
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<b>Total</b>				_____

**Co-ordination of Benefits**

Are you claiming for a dependent child who is age 21 or older?  No  Yes

Child is  physically/mentally handicapped (medical evidence may be requested) \_\_\_\_\_

a student enrolled full time at (school's name) \_\_\_\_\_

Are you or your dependents entitled to health benefits under any other plan?  No  Yes If "Yes," family member insured \_\_\_\_\_

Name of insuring company \_\_\_\_\_ Spouse's birthdate \_\_\_\_\_  
M/D/Y

**Accident Information**

Are any of the services provided as a result of an accident?  No  Yes If "Yes," enclose a brief description of the date and details of the accident.

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the benefit plan.

I certify that the answers to the above questions are full and true to the best of my knowledge and that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I authorize Maximum Benefit, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Maximum Benefit and its insurance companies to exchange information when necessary to assess my claim and to administer the group benefit plan. A photocopy of this authorization is as valid as the original when obtaining information.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ALL INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL**

**PLEASE SEE REVERSE**

BEND AND PEEL HERE



582 King Edward Street  
Winnipeg MB R3H 0P1



**PLEASE AFFIX THIS MAILING LABEL TO YOUR ENVELOPE.**