Sirius
Benefit Plans

EXTENDED HEALTH CLAIM FORM

See the other side for instructions

1	Member Information	Group #	Firm #	Firm Name		Certificate #
		Last Name		First Name		
		Street Address		City	Prov	Postal Code

2	Member Questions				
		Are you or your dependents entitled to benefits under any other plan?		☐ yes (see below)	☐ no
		If yes, please provide your spouse's name, date of birth and the name of the insuring company			
		Were any of the claimed services required as a result of an accident?		☐ yes If yes, provide detail on the other side	☐ no

3	Claimed Expenses			
		Patient Name	**Date of Birth**	**Relationship to Member**
		Service Type	**Service Date**	**Amount**
		Patient Name	**Date of Birth**	**Relationship to Member**
		Service Type	**Service Date**	**Amount**
		Patient Name	**Date of Birth**	**Relationship to Member**
		Service Type	**Service Date**	**Amount**

4	Member Signature	**I certify that the answers provided are full and true and that the attached receipts represent a claim for services. I hereby authorize Sirius Benefit Plans, healthcare providers, insurance or Reinsurance companies, administrators of benefit programs, other organizations and service providers to exchange personal information, when necessary, for the adjudication of the claims I submit and the administration of this benefit program. A photocopy of this is as valid as the original.**	
		Member Signature	Date signed