DEMANDE DE RÈGLEMENT

CLAIM FORM

EXTENDED HEALTH CARE BENEFITS

CES DOCUMENTS NE VOUS SERONT PAS RETOURNÉS, VEUILLEZ DONC EN CONSERVER DES COPIES POUR FINS DE VÉRIFICATION.

* *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.***

WERE EXPENSES INCURRED FOLLOWING AN ACCIDENT? *YES* *NO* *IF YES, PLEASE SPECIFY :*

PLACE

INDICATE WHY YOU RECEIVED MEDICAL AND/OR HOSPITAL CARE :

DESCRIBE THE SERVICES RECEIVED (EX. : EXAMS, X-RAYS, SURGERY, ETC.) IF NECESSARY, CONTINUE ON A SEPARATE PIECE OF PAPER.

ARE THE EXPENSES SUBMITTED COVERED UNDER ANY OTHER INSURANCE CONTRACT? *YES* *NO*

IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE CONTRACT? *YES* *NO*

IF YES :

CONTRACT NO. *INSURER'S NAME*

N.B. : THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT HIS CLAIM TO HIS INSURER. AFTERWARDS, PROVIDE BLUE CROSS GROUP BENEFITS WITH A COPY OF THE RECEIPTS WITH A 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.

VEUILLEZ COMPLÉTER LES INFORMATIONS AU VERSO. / ***PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM.***