Reset Form

MEDICAL AND DRUG EXPENSES CLAIM

the benefits trust

HOW TO SUBMIT YOUR CLAIMS:

To submit medical claims yourself, you have serveral options:

Without Using This Form: Download our Mobile Claim App or submit through our Online Claim Form (Links found in Employee Resource Centre)
Using This Form: By Fax: 905-264-1123
By Mail: The Benefits Trust, 1453 Pelham St., Fonthill, Ontario, L0S 1E0

Your Name: _____ Your Certificate Number: _____

Address: _____ Apt/Unit: _____

City: _____ Province: _____ Postal Code: _____

Employer: _____ Group / Policy Number: _____

Claims Section

List all prescriptions and/or items purchased. Please attach copy of receipts for every expense, and keep original receipts for 12 months from date of service. Attach your physician's written recommendation and diagnosis where applicable.

Name of Patient	Birth Date	Relationship To Employee	Date of Medical Expense	Name of Drug or Type of Purchase	Drug Identification No. (DIN)	Amount Charged
					TOTAL	

Refer to your benefits booklet or ask your employer to confirm who is considered an eligible dependant.
Submit Overage Dependant form if not already on file.

Coordination of Benefits

Is this medical care covered by any other group insurance? Yes ❑ No ❑ If Yes, Name of Insured: _____

Name of Insurance Company: _____ Policy Number: _____

Health Care Spending Account

(Expenses must be eligible under the Income Tax Act)

Do you want any part of this claim to be paid through your Health Care Spending Account? Yes ❑ No ❑

If Yes:
1) Please attach original receipts, or if expenses have been submitted under this or another plan and you are now claiming for the unpaid portion, please attach copies of the receipts, and the Explanation of Benefits from the previous submission.
2) Please indicate whether you want: All of the remaining portion of the claim to be paid ❑ or A specific amount ❑ $ _____

I hereby certify that the above information is true to the best of my knowledge and that these expenses were incurred by myself (or my dependants) for the exclusive use of the person for whom the expense was incurred, as indicated above. I authorize The Benefits Trust and its administrators to use my social insurance number for identification purposes in the handling of my claim. In addition, I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. An electronic or photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Signature of Covered Employee: _____ **Date:** _____