

CLAIM FORM - MEDICAL EXPENSES



Group#		Certificate/ID#	
Company Name			
Member Surname		First Name	
Date of Birth(day/month/year)		Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French	
Member's Address Apt #		Street# and Name	
City	Province	Postal Code	
Phone# Home		Work	
Cell Phone		Email	

Are your group health benefits payable from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company Name		Policy Number	Certificate Number
Are the expenses the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where did the accident occur? <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other			
Are any expenses the result of a condition covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			

MEDICAL EXPENSES (Attach original receipts for expenses listed below; do NOT staple or tape receipts to the claim form) Please print

Name (member or insured dependent)	Relationship to Member	Date of Birth			Total
		day	month	year	
1)					\$
2)					\$
3)					\$
4)					\$
5)					\$
6)					\$
7)					\$
8)					\$
9)					\$
Total					\$

Please check the box if any of the above expenses are for Hospital Indemnity.

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purpose of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement for the above charges and explanation of such amounts paid will be provided to the benefit plan member.

I authorize GroupHEALTH, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with GroupHEALTH to exchange necessary information regarding this claim to administer my health benefit plan.

Date: _____ Member's Signature: _____

Please submit your claim form by email (claims@mygrouphealth.ca) or by mail (myGroupHEALTH 626-21 Four Seasons Place, Etobicoke, ON M9B 0A6). If you have any questions, call us at 1-833-344-6944.



For quick and easy claim submission, submit claims at **mygrouphealth.ca** or with the **myGroupHEALTH app** available in the Apple App Store or Google Play.