



EXTENDED HEALTH BENEFITS CLAIM FORM



Please Return Completed Claims To: CINUP 491 Portage Avenue Winnipeg, MB R3B 2E4 Phone: 1-800-665-1234 Fax: 1-877-786-3889

PLEASE READ CAREFULLY BEFORE COMPLETING THE CLAIM.

- COMPLETE THE CLAIM BY ENTERING THE APPROPRIATE AMOUNT IN EACH OF THE SPACES BELOW.
• ENCLOSE ITEMIZED RECEIPTS FOR EACH SERVICE.
• RECEIPTS WILL NOT BE RETURNED - PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.
• FOR BENEFITS ASSIGNED TO PROVIDERS, ENCLOSE ITEMIZED STATEMENTS FOR EACH SERVICE.
• CLAIMS MUST BE SUBMITTED WITHIN 2 YEARS OF DATE OF SERVICE, UNLESS OTHERWISE STATED IN POLICY PROVISIONS.
• PLEASE RETAIN OUR EXPLANATION OF BENEFITS FOR COORDINATION OF BENEFITS OR INCOME TAX PURPOSES.

POLICY 3D1V11012345 CERTIFICATE NO. 1012345 EMPLOYEE NAME BOBBY SMITH CLAIMANT NAME BOBBY SMITH BIRTH DATE 30/11/72
EMPLOYEE ADDRESS 123 MARKET STREET CITY WINNIPEG TOWN POSTAL CODE R0A0A0 HAS YOUR ADDRESS CHANGED IN THE PAST YEAR YES NO

WAS TREATMENT THE RESULT OF AN INJURY AT THE WORK PLACE? YES NO A MOTOR VEHICLE ACCIDENT? YES NO

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED? YES NO IF YES, COMPLETE THE FOLLOWING
POLICY HOLDER OF OTHER PLAN MARY SMITH (SPOUSE) BIRTH DATE 30/11/72 EMPLOYER ABC COMPANY EMPLOYER'S INSURANCE COMPANY DEG COMPANY POLICY OR CONTRACT NUMBER 1234

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER AND COPIES OF THE RECEIPTS.

IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:
1. AGE OF CHILD
2. IS HE/SHE MARRIED? YES NO IF YES, DATE OF MARRIAGE
3. IS HE/SHE EMPLOYED FULL-TIME? YES NO IF YES, DATE FULL TIME EMPLOYMENT STARTED
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? YES NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? YES NO

Table with 2 columns: BENEFITS CLAIMED, TOTAL AMOUNT

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IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? YES NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER: PROVIDER NUMBER 567890 NAME DR. PHYSIOTHERAPIST ADDRESS 125 STREET WINNIPEG POSTAL CODE R0A0A0

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? YES NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER: PROVIDER NUMBER 567890 NAME DR. PHYSIOTHERAPIST ADDRESS 125 STREET WINNIPEG POSTAL CODE R0A0A0

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE POLICY.

I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT. EMPLOYEE'S SIGNATURE B. Smith

SIGNATURE OF EMPLOYEE (OR PARENT/GUARDIAN) B. Smith (PLEASE SIGN HERE) DATE 8/5/08

BLUE CROSS OFFICE USE ONLY RECEIVED ASSESSED CHECKED AUDIT INIT. INIT.