

PLEASE READ CAREFULLY BEFORE COMPLETING CLAIM FORM:

- REFER TO YOUR GROUP AGREEMENT TO DETERMINE THE BENEFITS TO WHICH YOU MAY BE ENTITLED.
- PLEASE PRINT CLEARLY AND COMPLETE ALL QUESTIONS.
- RETAIN SECOND COPY OF THIS CLAIM FOR YOUR RECORDS.
- SUBMIT ORIGINAL RECEIPTS.

CONTRACT NUMBER 01 45678	GROUP NUMBER 12345	PATIENT SURNAME SMITH	FIRST NAME SUSAN	MHSC #	PHIN #
BIRTH DATE DAY: 01 MONTH: 01 YEAR: 72					

EMPLOYER NAME: ABC Company

ARE ANY BENEFITS PROVIDED UNDER ANY OTHER INSURANCE PLAN?  
 YES  NO IF YES, COMPLETE THE FOLLOWING:  
 NAME OF INSURER: \_\_\_\_\_  
 POLICY OR CONTRACT NUMBER: \_\_\_\_\_  
 PERSON INSURED: \_\_\_\_\_

DATE OF DEPARTURE FROM HOME PROVINCE: Jan 10, 2006  
 DATE OF ORIGINALLY SCHEDULED RETURN: Jan 17, 2006  
 DATE OF FIRST TREATMENT: Jan 12, 2006

**MUST BE COMPLETED BY SUBSCRIBER**

ARE YOU PRESENTLY A FULL-TIME OR PERMANENT PART-TIME EMPLOYEE WORKING A MINIMUM OF 20 HOURS A WEEK OTHER THAN USUAL VACATION TIME AND PERFORMING ALL REGULAR DUTIES OF THAT OCCUPATION?  
 YES  NO

DESCRIBE REASONS FOR SEEKING MEDICAL ATTENTION AND NATURE OF ILLNESS OR INJURY

Broken leg

ATTENDING PHYSICIAN: NAME: _____ COUNTRY: _____ FAMILY PHYSICIAN AT HOME: NAME: _____ ADDRESS: _____	IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING: 1. AGE OF CHILD _____ 2. IS HE/SHE UNMARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. IS HE/SHE EMPLOYED FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF COLLEGE OR UNIVERSITY: _____ IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT <input type="checkbox"/> YES <input type="checkbox"/> NO
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ARE INJURIES A RESULT OF AN ACCIDENT?  YES  NO IF YES, COMPLETE THE FOLLOWING:

TYPE OF ACCIDENT: Fall LOCATION OF ACCIDENT: Cancun, Mexico  
 DATE OF ACCIDENT: Jan 12, 2006 NAME AND ADDRESS OF LAWYER REPRESENTING YOU WITH RESPECT TO ACCIDENT: n/a  
 DETAILS OF ACCIDENT: Slipped + fell.

STATEMENT OF EXPENSES (ATTACH RECEIPTS)				FOR BLUE CROSS USE ONLY			
BILLING AGENCY	DATE OF SERVICE	TOTAL BILLED (FOREIGN FUNDS)	TOTAL BILLED (CANADIAN FUNDS)	PAID BY GOVERNMENT PLAN (CAN.)	PAID BY GOVERNMENT PLAN (U.S.)	MANITOBA BLUE CROSS BALANCE	RATE OF EXCHANGE
HOSPITAL OUT-PATIENT							
HOSPITAL IN-PATIENT							
MEDICAL CHARGES							
AMBULANCE							
PRESCRIPTION DRUGS							
OTHER							
TOTAL							TOTAL

*see attached invoice*

BLUE CROSS USE ONLY BENEFIT CODE: \_\_\_\_\_ ASSESSED BY: \_\_\_\_\_ APPROVED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

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 CONTRACT. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ENTIRE COST OF SERVICES RECEIVED.

DATE: Jan 20/06 RES. PHONE: 555-5555 BUS. PHONE: 551-5555

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: Susan Smith

IF THERE IS A CHARGE FOR COMPLETING THIS FORM IT IS THE RESPONSIBILITY OF THE INDIVIDUAL CLAIMING THE BENEFIT.

NAME AND ADDRESS OF TO WHOM PAYMENT IS TO BE MADE:  
 NAME: See attached invoice  
 ADDRESS: \_\_\_\_\_  
 POSTAL CODE: \_\_\_\_\_