EXTENDED HEALTH CLAIM FORM

See the other side for instructions

1	**Member Information**	Group #	Firm #	Firm Name	Certificate #
		Last Name		First Name	
		Street Address	City	Prov	Postal Code

2	**Member Questions**	**Are you or your dependents entitled to benefits under any other plan?**	☐ yes (see below)	☐ no
		If yes, please provide your spouse's name, date of birth and the name of the insuring company	Name	Date of Birth DD / MM / YYYY	Name of Insuring Co.
		Were any of the claimed services required as a result of an accident?	☐ yes If yes, provide detail on the other side	☐ no

3	**Claimed Expenses**		
	Patient Name	**Date of Birth** DD / MM / YYYY	**Relationship to Member**
	Service Type	**Service Date**	**Amount**
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
	Patient Name	**Date of Birth** DD / MM / YYYY	**Relationship to Member**
	Service Type	**Service Date**	**Amount**
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
	Patient Name	**Date of Birth** DD / MM / YYYY	**Relationship to Member**
	Service Type	**Service Date**	**Amount**
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	

4	**Member Signature**	**I certify that the answers provided are full and true and that the attached receipts represent a claim for services. I hereby authorize Sirius Benefit Plans, healthcare providers, Insurance or Reinsurance companies, administrators of benefit programs, other organizations and service providers to exchange personal information, when necessary, for the adjudication of the claims I submit and the administration of this benefit program. A photocopy of this is as valid as the original.**	
		Member Signature	Date signed DD / MM / YYYY

5	Instructions	**All original receipts must accompany this claim**, except in the case where the services were previously paid by other insurance coverage, in which case the EOB (Explanation of Benefits) from the prior carrier must be attached. **<u>RECEIPTS WILL NOT BE RETURNED TO YOU</u>**, unless they are for an expense that is not eligible under this plan. If you wish to retain a copy of receipts for your files, please make a copy prior to submitting them. The Explanation of Benefits, which is produced when the claim is adjudicated, is sufficient information for income tax. **Hospital claims** must be submitted on a hospital claim form which is available at the hospital that provided the services. There are services that may require the submission of additional information in order for the claim to be adjudicated. It is recommended that you **refer to your booklet** to ensure that the claim is not delayed by outstanding information. For example, to submit a claim for an Orthotic service, the claim must be accompanied by a letter from the physician indicating the referral and diagnosis of the condition. **Incomplete claim forms** may be returned for completion or delayed pending further information. Please ensure you complete all sections of the form prior to submission. Mail your completed claims forms to: Health and Dental Claims Sirius Benefit Plans 221-2025 Corydon AV Winnipeg MB R3P 0N5

2	If treatment is as a result of an accident, provide the details of the accident; such as the date and location of accident. Provide an explanation of how the accident occurred.	

DID YOU KNOW?

It is recommended that you submit your claim expenses at least once every 3 months.