HUMANIA ASSURANCE MD®

Claim form
Medical and paramedical fees

For information, please contact us at:
Individual Insurance: Telephone: 450 773-7170 / 514 489-8404 / Toll free: 1 800 773-8404
Group Insurance: Telephone: 450 773-7236 / 514 485-7236 / toll free: 1 800 818-7236
Fax: 450 778-2519 / Email: claims@humania.ca / **Web site:** www.humania.ca
Our address is: 1555, Girouard Street West, Saint-Hyacinthe (Quebec) J2S 2Z6

IMPORTANT

1. If possible, please do not submit a claim until incurred expenses total at least $100 or an amount equivalent to the deductible.
2. For covered expenses exceeding $500, please submit an estimate in writing first to verify eligibility of expenses.
3. Attach original receipts and keep copies for your records. All receipts will be destroyed. The statement of benefits and copies of your receipts are sufficient for income tax and benefit coordination purposes.

Claimant statement
To be completed by the claimant. Please note that all questions must be answered in as much detail as possible.

Section A – General information

Policy n° _____ Certificate n° _____ Date of birth _____ (YYYY/MM/DD)

☐ Mr. ☐ Mrs. ☐ Ms. Name _____ Given name(s) _____

Address (n°, street) _____ Apt. _____

City _____ Province _____ Postal code _____ Telephone n° _____ Language ☐ Fr. ☐ En.

Name of the employer (and division if different) _____

Section B – Dependents – To be completed the first time you submit a claim for a dependent child or spouse or whenever there is a change.

Name	Given names(s)	Date of birth

IMPORTANT

If you are claiming for a dependent child aged 21 or over, who is a full time student at a recognised educational establishment, please forward a proof of registration.

Section C – Coordination of benefits – To be completed if any expenses you are claiming for are covered by another plan.

Claiming instructions: for his/her expenses, your spouse must claim first to his/her insurer. Children's claims must be submitted to the insurer of the parent whose date of birth occurs first in the calendar year. If a claim was already processed by another insurer, please submit a copy of their explanation of benefits and copies of receipts.

Name of your spouse's group insurer	Policy n°	Certificate n°

Coverage: **Health care** ☐ Single ☐ Family **Dental care** ☐ Single ☐ Family

Effective date of coordination of benefits (YYYY/MM/DD) _____

Cancellation date of coordination of benefits (if applicable) (YYYY/MM/DD) _____

Please complete the reverse side.

Claimant statement (continued)

Section D – Medical fees

Drugs

The receipts must show patient name, drug name and drug identification number (DIN).

Total amount of your drug claims : $ _____.

Medical and paramedical expenses

Receipts must indicate the provider name and address and all dates of visits or any exams and detailed related costs. Always refer to your booklet to confirm coverage for different health practitioners and attach physician referrals where required by your contract.

Total amount of your medical and paramedical claims : $ _____.

Vision care

Receipts must indicate the provider name and address, and show separate costs for contact lenses, frames and lenses for glasses, cost and date of eye exams.

Total amount of your vision care claims : $ _____.

Section E – Health & Dental Spending Budget – If you have this coverage, please mark whished options.

If this section is not completed, the claim will be processed according to your basic coverage and no request to modify the option will be accepted. Only medical fees recognised by the Federal tax law are eligible.

❑ **1.** I do not wish to use my Health & Dental Spending Budget.

❑ **2. Ineligible expenses** – I wish to use my Health & Dental Spending Budget to cover expenses that are not reimbursed under my group insurance : Amount to be applied : _____ $

❑ **3. Spouse's family coverage** – I wish to use my Health & Dental Spending Budget for myself and my dependent children to cover expenses that are not reimbursed under my group insurance. I will not submit a claim to my spouse's insurer (coordination of benefits) : Amount to be applied : _____ $

❑ **4. Services requiring a medical recommendation** – I wish to use my Health & Dental Spending Budget to cover the expenses related to such services when I do not have a medical recommendation : Amount to be applied : _____ $

Section F – Fees related to an accident

Please describe the accident

Has any portion of these expenses been submitted to a government body for reimbursement (WSIB, CSST, SAAQ, …)? ☐ Yes ☐ No

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Section G – Claimant authorization and declaration

I authorize Humania Assurance, its agents, service providers and other partners (hereinafter "*Business Partners*") to collect, by any electronic means, email, fax or mail and to use all personal information relevant to the adjudication of the claim submitted under this insurance policy as well as for statistical purposes.

I further authorize Humania Assurance to exchange the personal information collected about me with its *Business Partners*, whether located in or outside Quebec, where the exchange of such information is necessary to carry out their mandate.

This authorization applies to my personal information held by any natural or legal person, including but not limited to any physician or other health professional, any public or private health institution, any rehabilitation company, any pharmacist, any provincial health insurance plan, including but not limited to the Régie de l'assurance maladie du Québec, any insurer, any employer or any other person or institution in possession of medical or financial information about me. This authorization also applies to any other personal information contained on social media or on any Internet platform accessible to the public.

A paper or digital copy of this authorization is as valid as the original. An electronic signature has the same value as a handwritten signature.

By providing my email address below, I authorize Humania Assurance to communicate with me by email concerning my present claim.

I declare that I am aware of the rights granted by the *Act respecting the protection of personal information in the private sector,* including but not limited to the right to access my information, the right to have that information corrected, if need be, and the right to withdraw, at any time, this authorization to share and use my personal information.

Name (Please print)	Signature
Policy No.	Date (AAAA/MM/JJ)
	Email Address

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6