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.

HUMANIA ASSURANCE MD®

Claim form
Medical and paramedical fees

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

Section G – Claimant authorization and declaration

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance Inc. all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance Inc. to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance Inc. will use the information provided in this form and in any prior claims under the same plan for the management of my claim and for production of statistical reports.

I certify that the information contained in this form is true and complete.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

_____ Name (please print)

_____ **Signature**

_____ Policy n°

_____ **Date** (YYYY/MM/DD)

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.

HUMANIA ASSURANCE MD®

Claim form
Medical and paramedical fees

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

Section G – Claimant authorization and declaration

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance Inc. all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance Inc. to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Humania Assurance Inc. will use the information provided in this form and in any prior claims under the same plan for the management of my claim and for production of statistical reports.

I certify that the information contained in this form is true and complete.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is as valid as the original.

_____ Name (please print)

_____ **Signature**

_____ Policy n°

_____ **Date** (YYYY/MM/DD)