CINUP

EXTENDED HEALTH CLAIM

Please print your Division & Certificate # | Division # | Certificate #

EMPLOYEE INFORMATION

1

Firm Name _____

Employee's Full Name _____

Home Mailing Address _____
Apartment/Street | City / Town | Province | Postal Code

Please provide a phone number where we can reach you during the day if we have any questions about your claim. (____) _____

2

Patient's Name	Birthday YYYY/MM/DD	Relation to Employee	Service Type	Total Amount Charged/Patient
			Total	

COORDINATION OF BENEFITS

3

Are you claiming for a dependent child? ☐ No ☐ Yes If "Yes," age of child_____

Child is ☐ physically/mentally handicapped (medical evidence may be required)

☐ a student enrolled **full time** at (school name)_____

Are you or your dependents entitled to health benefits under any other plan? ☐ No ☐ Yes

If "Yes," family member insured _____

Name of insuring company _____ Spouse's birthdate _____
YYYY/MM/DD

ACCIDENT INFORMATION

Are any of the services provided as a result of an accident? ☐ No ☐ Yes

If "Yes," enclose a brief description of the date and details of the accident.

HEALTH SPENDING ACCOUNT

If your firm has a Health Spending Account, please apply the balance of this claim towards this benefit. ☐ No ☐ Yes

4

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

If this claim includes an amount under my Health Spending Account, I certify that the amount qualifies as a medical expense for income tax purposes. I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

I authorize CINUP to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

Please mail this completed form and your receipts to

CINUP Group Benefits, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1 1-800-665-1234 | Fax 1-800-457-8410

Insuring Company: Desjardins Insurance

INSTRUCTIONS (PLEASE READ CAREFULLY)

We need your receipts, **OR** the Explanation of Benefit statement and copies of receipts from any plan that has already paid a portion of the expense, to process your claim. Please staple your receipts or statement with copies to this form. **We do not return receipts.**

Receipts must include the service date; a complete breakdown of charges; and the practitioner's name, credentials, address, and phone number.

Before mailing this form, make sure all questions on this form are answered. If you send an incomplete form, your claim may take longer to process.

Expenses paid by your group benefit plan are not eligible income tax deductions. You may be eligible to claim any amounts not covered by the Plan. Your Explanation of Benefits will be accepted as proof of amounts not covered by the Plan.