ContinYou™

JG17-CY

EXTENDED HEALTH CLAIM

Please print your Policy & Certificate #

Policy #	Certificate #

Covered Individual Information

Covered Individual'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. (____) _____

Patient's Name	Birthday M/D/Y	Relation to Individual	Service Type	Total Amount Charged/Patient
			Total	

Co-ordination of Benefits

Are you claiming for a dependent child who is age 21 or older? ❑ No ❑ Yes

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 _____
M/D/Y

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.

Declaration and Authorization for the Collection and Communication of Personal Information

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.

I authorize Johnston Group Inc. and Co-operators Life Insurance Company 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.

Covered Individual's Signature _____ Date _____

ALL INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL

Please mail this completed form and your original receipts to
NATIONAL SERVICE CENTRE, 1051 King Edward Street, Winnipeg, MB R3H 0R4
Telephone 1-800-893-7587

ContinYou™

JG17-CY

EXTENDED HEALTH CLAIM

Instructions (Please read carefully)

We need your original 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 original 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 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.