MEDAVIE BLUE CROSS™

HEALTH SPENDING ACCOUNT/ PERSONAL WELLNESS ACCOUNT

MEMBER INFORMATION

ID Number: _____ Policy Number: _____

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ○ Yes ○ No If yes, signature of member is required for validation: _____

OTHER COVERAGE

Do you or any dependents have coverage under any other plan?

○ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

○ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ○ **Individual** ○ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ○ Hospital ○ Travel ○ Extended Health ○ Drugs ○ Vision ○ Dental ○ **All**

HEALTH SPENDING ACCOUNT / PERSONAL WELLNESS ACCOUNT SELECTION

All eligible services will be assessed under your base plan.

Do you want this claim processed through your Health Spending Account? ○ Yes ○ No

Do you want this claim processed through your Personal Wellness Account? ○ Yes ○ No

CLAIM INFORMATION

	CLAIMANT'S NAME		RELATIONSHIP TO MEMBER Self, Spouse, Child	DATE OF BIRTH			TYPE OF SERVICE	DATE OF SERVICE			AMOUNT PAID
	First Name	Last Name		day	month	year		day	month	year	
1											
2											
3											
4											
5											
6											
										TOTAL CLAIM AMOUNT	

MEMBER STATEMENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by my Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life) plan may be collected, used, or disclosed to administer and manage the terms of my plan of which I am an eligible member or dependent, to recommend suitable products and services to me, and to manage my Medavie Blue Cross and/or Blue Cross Life plan's business. For the purposes listed above, limited personal information may be collected from and /or released to a third party. This third party may include another Medavie Blue Cross and/or Blue Cross Life organization, a licensed physician, health care professional or institution, life and health insurer, government and regulatory authorities, the member of any plan under which I am a dependent or another third party.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent my Medavie Blue Cross and/or Blue Cross Life plan from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. **I authorize my Medavie Blue Cross and/or Blue Cross Life plan to collect, use and disclose my personal information as described above.**

All medical expenses must be claimed through your provincial and group insurance plans before payment can be made from a Health/Personal Wellness Account. I confirm that benefits under this plan, any government program or alternate group plan (i.e. spouse's/partner's coverage) have been accessed.

I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. If claiming expenses for an uninsured dependent under your Health/Dental contract, I, the undersigned, accept full responsibility that this dependent qualifies under the Canadian Federal Income Tax Act as an eligible dependent.

MEMBER Signature _____ Date _____

This consent complies with federal and provincial privacy laws.

MEDAVIE BLUE CROSS ADDRESSES

Atlantic Provinces
PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Quebec
PO Box 3300 STN B
Montreal QC H3B 4Y5
Inquiries: 1-800-667-4511

Ontario
PO Box 2000 STN A
Etobicoke ON M9C 5P1
Inquiries: 1-800-667-4511

Other Provinces and Territories
PO Box 2318 STN Main
Edmonton AB T5J OL8
Inquiries: 1-800-667-4511

*** Please ensure all areas are complete. Incomplete information may delay processing.**
*** Please attach all original paid-in-full receipts or an EOB from the primary carrier and photocopies of receipts.**
*** Prescription drug receipts must indicate: name, strength and quantity of drug, drug identification number (DIN), prescription number (RX) and patient name.**
*** Original receipts will not be returned.**
*** All receipts should indicate: name of supplier/provider, item/service rendered, provider telephone number.**