



HEALTH CLAIM FORM

Plan Member's Full Name, Group or Employer, Personal Identification No., Group#, I.D.#, Date of Birth, Day / Month / Year

Plan Member's Address, Street, Apt., City, Province, Postal Code, Telephone No., Email, Language Preference (English, French)

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENT

Table with columns: Dependent's name (Last, First), Date of Birth (Day, Month, Year), Relationship to Plan Member (Spouse, Daughter, Son, Other (describe))

EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

Table with columns: Nature of expense, Date incurred (dd/mm/yyyy), Recommended by: Physician's name, Amount

1. Are any health benefits or services provided under any other plan... 2. Name of other insuring agency or... Total Claim \$, 2 a. If yes, indicate member under other plan: Self Spouse, Policy No., Certificate No., Name, Date of Birth, N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year. 3. Do you want any unpaid balance from this claim reimbursed from your health service spending account (if eligible)? Yes No

*** Note: Do NOT staple or tape receipts to the claim form ***

I certify that I have read and understood the Grandeur Privacy Policy posted on Grandeur Group Benefits Inc.'s ("Grandeur") website at http://grandeurbenefits.com/ (the "Policy") and I consent to the collection, use and disclosure of my personal information for the purposes of group benefits plan administration, including, adjudicating, assessing and processing my claim, audit, investigation, underwriting or determining plan eligibility, and for communicating with me about my claim ("Purposes").

Date: _____ Plan Member's Signature: _____

All information recorded on this form is confidential Send all claims and inquiries to:

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