Cowan

HEALTHCARE CLAIM FORM

EMPLOYEE STATEMENT

Group Contract Number _____ Certificate Number _____

Employee Last name and given name _____ Date of birth (MM/DD/YY) _____

Employee Address: _____

WOULD YOU LIKE YOUR CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT? YES☐ I have included a void cheque.
Please note that only a one time void cheque is required. If you change your banking information, a new void cheque will be needed.

COORDINATION OF BENEFITS

1. Does your spouse and/or children have coverage under any other medical plan or contract? ☐ Yes ☐ No

If yes, spouse's date of birth? (MM/DD/YY)_____

Insurance company, policy number and certificate number _____

2. Is any expense the result of an accident? ☐Yes ☐No

If yes, Date of accident _____ Location of accident Work☐ Home☐ Other☐

Explain how the accident occurred _____

3. If this claim is for a child 21 years of age or older, please indicate the following: Is the child handicapped☐ Is the child a full time student☐

DRUGS, VISION CARE, PARAMEDICAL SERVICES AND OTHERS – PATIENT INFORMATION

Patient's name (Use one line per patient)	Date of birth Month	Day	Year	Relationship to plan member	Total charge
			TOTAL FEE SUBMITTED		

REMINDER

PLEASE REFER TO YOUR EMPLOYEE SUMMARY OF BENEFITS TO CONFIRM THE AMOUNT OF TIME YOU HAVE TO SUBMIT A CLAIM.

THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE RETURNED TO YOU, WHICH WILL DELAY THE PROCESSING OF THE CLAIM.

PRESCRIPTION DRUGS

Please attach your original receipts to the back of this form.
All drug receipts must contain the drug identification and the name of the prescription drug.

VISION CARE – ASSIGNMENT OF BENEFITS

PROVIDER

Name and address of provider:

Telephone:

I hereby assign my benefits payable from this claim to the named provider and authorize payments directly to him/her.

Signature of employee Date

AUTHORIZATION

I, the undersigned, authorize the Cowan Insurance Group ("*CIG*"), my employer, my plan administrator, physician, health care professional, hospital, medical facility, insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with CIG, or its representatives, all medical or benefit payment information or any other information or records in its possession that CIG may hold or request for the purposes of adjudicating this claim.

I certify that the information I am submitting in support of my claim is true and complete to the best of my knowledge and belief. I understand that CIG may investigate my claim by collecting additional relevant personal information about me or my dependents from me and/or from other third parties. In cases of suspected fraud or plan abuse, CIG will investigate and I agree that CIG may share information with regulatory bodies, government or police agencies, healthcare professionals and the plan administrator or employer, if appropriate.

I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____ **Member** signature: _____

MAIL YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:

Cowan Insurance Group
700-1420 Blair Place Ottawa, Ontario K1J 9L8
Telephone:
1-888-509-7797 or 1-613-741-3313