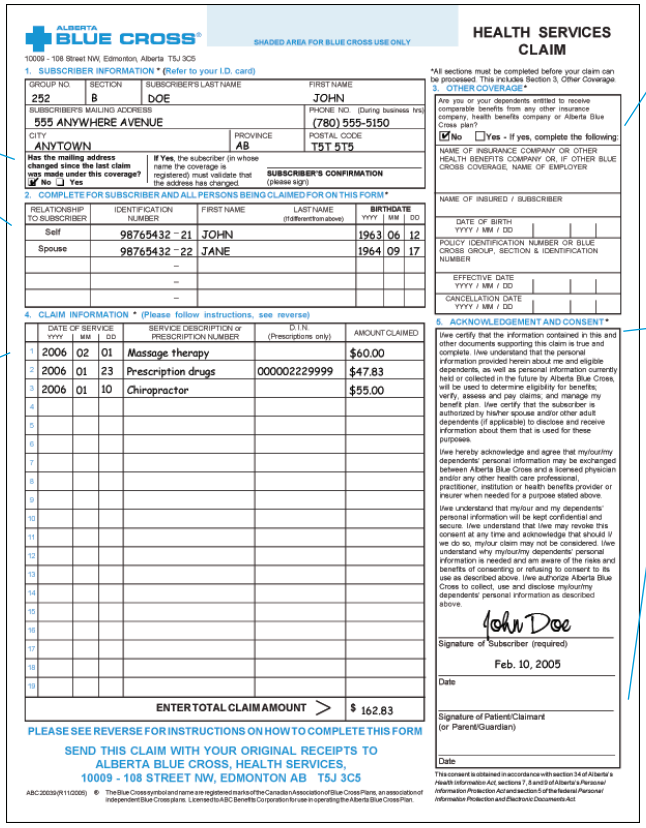
HOW TO COMPLETE YOUR CLAIM FOR EXTENDED HEALTH BENEFIT EXPENSES

1 Complete all the subscriber information in Section 1 and Section 2 (*Self*). If you are claiming for your spouse, and/or dependents, please include them in Section 2.

2 **Every receipt you are submitting must be indicated in Section 4 with all corresponding fields completed or the form will be sent back for you to complete and sign.** Out-of-country expenses must be claimed on a separate *Alberta Blue Cross Travel Claim Form* and dental services, including accidental dental claims, must be claimed using the *Alberta Blue Cross Dental Claim Form*.



ALBERTA BLUE CROSS®

SHADED AREA FOR BLUE CROSS USE ONLY

HEALTH SERVICES CLAIM

10009 - 108 Street NW, Edmonton, Alberta T5J 3C5

1. SUBSCRIBER INFORMATION * (Refer to your I.D. card)

GROUP NO.	SECTION	SUBSCRIBER'S LAST NAME	FIRST NAME
252	B	DOE	JOHN

SUBSCRIBER'S MAILING ADDRESS: 555 ANYWHERE AVENUE — PHONE NO. (During business hrs): (780) 555-5150

CITY: ANYTOWN — PROVINCE: AB — POSTAL CODE: T5T 5T5

Has the mailing address changed since the last claim was made under this coverage? ☑ No ☐ Yes — If Yes, the subscriber (in whose name the coverage is registered) must validate that the address has changed. SUBSCRIBER'S CONFIRMATION (please sign)

2. COMPLETE FOR SUBSCRIBER AND ALL PERSONS BEING CLAIMED FOR ON THIS FORM *

RELATIONSHIP TO SUBSCRIBER	IDENTIFICATION NUMBER	FIRST NAME	LAST NAME (if different from above)	BIRTHDATE YYYY	MM	DD
Self	98765432 – 21	JOHN		1963	06	12
Spouse	98765432 – 22	JANE		1964	09	17
	–					
	–					
	–					

4. CLAIM INFORMATION * (Please follow instructions, see reverse)

	DATE OF SERVICE YYYY	MM	DD	SERVICE DESCRIPTION or PRESCRIPTION NUMBER	D.I.N. (Prescriptions only)	AMOUNT CLAIMED
1	2006	02	01	Massage therapy		$60.00
2	2006	01	23	Prescription drugs	000002229999	$47.83
3	2006	01	10	Chiropractor		$55.00
4						
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ENTER TOTAL CLAIM AMOUNT > $ 162.83

PLEASE SEE REVERSE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO ALBERTA BLUE CROSS, HEALTH SERVICES, 10009 - 108 STREET NW, EDMONTON AB T5J 3C5

ABC20039(R11/2005) © The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan.

*All sections must be completed before your claim can be processed. This includes Section 3, Other Coverage.

3. OTHER COVERAGE *

Are you or your dependents entitled to receive comparable benefits from any other insurance company, health benefits company or Alberta Blue Cross plan? ☑ No ☐ Yes - If yes, complete the following:

NAME OF INSURANCE COMPANY OR OTHER HEALTH BENEFITS COMPANY OR, IF OTHER BLUE CROSS COVERAGE, NAME OF EMPLOYER

NAME OF INSURED / SUBSCRIBER

DATE OF BIRTH YYYY / MM / DD

POLICY IDENTIFICATION NUMBER OR BLUE CROSS GROUP, SECTION & IDENTIFICATION NUMBER

EFFECTIVE DATE YYYY / MM / DD

CANCELLATION DATE YYYY / MM / DD

5. ACKNOWLEDGEMENT AND CONSENT *

I/we certify that the information contained in this and other documents supporting this claim is true and complete. I/we understand that the personal information provided herein about me and eligible dependents, as well as personal information currently held or collected in the future by Alberta Blue Cross, will be used to determine eligibility for benefits; verify, assess and pay claims; and manage my benefit plan. I/we certify that the subscriber is authorized by his/her spouse and/or other adult dependents (if applicable) to disclose and receive information about them that is used for these purposes.

I/we hereby acknowledge and agree that my/our/my dependents' personal information may be exchanged between Alberta Blue Cross and a licensed physician and/or any other health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I/we understand that my/our and my dependents' personal information will be kept confidential and secure. I/we understand that I/we may revoke this consent at any time and acknowledge that should I/we do so, my/our claim may not be considered. I/we understand why my/our/my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above. I/we authorize Alberta Blue Cross to collect, use and disclose my/our/my dependents' personal information as described above.

John Doe

Signature of Subscriber (required)

Feb. 10, 2005

Date

Signature of Patient/Claimant (or Parent/Guardian)

Date

This consent is obtained in accordance with section 34 of Alberta's Health Information Act, sections 7, 8 and 9 of Alberta's Personal Information Protection Act and section 5 of the federal Personal Information Protection and Electronic Documents Act

3 This section must be completed, even if you only check the "No" box. If, however, you, your spouse, or any dependents are entitled to receive comparable benefits for the expense or services being claimed from any other health benefit plan (including another Blue Cross plan), the remainder of Section 3 (*Other Coverage*) must be completed.

4 Please ensure you have read and understood Section 5, *Acknowledgement and Consent*. In doing so, the subscriber should ensure that:

- all individuals for whom this claim is made are eligible under his/her plan, and
- your spouse and eligible adult dependents are aware and have authorized the subscriber to disclose and receive information about their claims made under this plan.

5 By submitting this claim form, the subscriber, spouse and eligible adult dependents who are claiming agree to the provisions of the *Acknowledgement and Consent*.

RECEIPTS

1. Attach original receipts for each expense claimed and **keep copies for your records, as these receipts will not be returned**. If you have claimed these expenses under another plan, the original Explanation of Benefits (see explanation) from that plan and **copies** of receipts **must** be attached to this claim. All original receipts must indicate the following information: first and last name of individual receiving the service, date or dates on which the service was obtained, the service or product purchased, the provider of service's name and address and the amount charged.

NOTE: Receipts/invoices with incomplete information will be rejected.

OTHER COVERAGE (Coordination of Benefits)

Coordination of Benefits (COB) is a standard practice among benefit carriers in Canada. COB allows people with more than one plan to maximize their coverage.

If you are claiming expenses for your spouse and your spouse is covered for those expenses under another health benefit plan, you must submit the claim to your spouse's plan first. If both you and your spouse have health benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first.

EXPLANATION OF BENEFITS AND CLAIMS PAYMENT

An Explanation of Benefits statement, indicating how this claim was assessed, will be sent to the subscriber to be used for income tax purposes or to claim under other coverage. If you are being reimbursed, a cheque will accompany the statement. If your claim is complete with all the necessary receipts and documents, the Explanation of Benefits and cheque (if appropriate) will be mailed approximately two weeks after we receive your claim.

EDMONTON	(780) 498-8000
CALGARY	(403) 234-9666
FORT MCMURRAY	(780) 790-3390
GRANDE PRAIRIE	(780) 532-3505
LETHBRIDGE	(403) 328-1785
MEDICINE HAT	(403) 529-5553
RED DEER	(403) 343-7009

Toll free from areas outside these major centres:

1-800-661-6995

Questions about privacy? (780) 498-8100 ext. 8108

Visit our web site at: **www.ab.bluecross.ca**

MAIL YOUR CLAIM TO:

Alberta Blue Cross
Health Services
10009 – 108 Street NW
Edmonton, AB T5J 3C5

ALBERTA BLUE CROSS®

10009 - 108 Street NW, Edmonton, Alberta T5J 3C5

SHADED AREA FOR BLUE CROSS USE ONLY

HEALTH SERVICES CLAIM

*All sections must be completed before your claim can be processed. This includes Section 3, *Other Coverage.*

1. SUBSCRIBER INFORMATION * (Refer to your I.D. card)

GROUP NO.	SECTION	SUBSCRIBER'S LAST NAME	FIRST NAME

SUBSCRIBER'S MAILING ADDRESS	PHONE NO. (During business hrs)

CITY	PROVINCE	POSTAL CODE

Has the mailing address changed since the last claim was made under this coverage?
☐ **No** ☐ **Yes**

If Yes, the subscriber (in whose name the coverage is registered) must validate that the address has changed.

SUBSCRIBER'S CONFIRMATION
(please sign)

2. COMPLETE FOR SUBSCRIBER AND ALL PERSONS BEING CLAIMED FOR ON THIS FORM *

RELATIONSHIP TO SUBSCRIBER	IDENTIFICATION NUMBER	FIRST NAME	LAST NAME (If different from above)	BIRTHDATE YYYY	MM	DD
Self	–					
Spouse	–					
	–					
	–					
	–					

3. OTHER COVERAGE *

Are you or your dependents entitled to receive comparable benefits from any other insurance company, health benefits company or Alberta Blue Cross plan?

☐ **No** ☐ **Yes -** If yes, complete the following:

NAME OF INSURANCE COMPANY OR OTHER HEALTH BENEFITS COMPANY OR, IF OTHER BLUE CROSS COVERAGE, NAME OF EMPLOYER

NAME OF INSURED / SUBSCRIBER

DATE OF BIRTH YYYY / MM / DD

POLICY IDENTIFICATION NUMBER OR BLUE CROSS GROUP, SECTION & IDENTIFICATION NUMBER

EFFECTIVE DATE YYYY / MM / DD

CANCELLATION DATE YYYY / MM / DD

4. CLAIM INFORMATION * (Please follow instructions, see reverse)

	DATE OF SERVICE YYYY	MM	DD	SERVICE DESCRIPTION or PRESCRIPTION NUMBER	D.I.N. (Prescriptions only)	AMOUNT CLAIMED
1						
2						
3						
4						
5						
6						
7						
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12						
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				ENTER TOTAL CLAIM AMOUNT >		$ 0.00

5. ACKNOWLEDGEMENT AND CONSENT *

By submitting this claim form to Alberta Blue Cross, I/we agree to the provisions of this Acknowledgement and Consent as follows, and:**

- confirm that these services have been received and paid for prior to the date of this claim
- certify that the information contained in this and other documents supporting this claim is true and complete
- understand that the personal information provided herein about me and eligible dependents, as well as other personal information currently held or collected in the future by Alberta Blue Cross, will be used only to determine eligibility for benefits; verify, assess and pay claims; and administer the terms of my benefit plan
- certify that the subscriber is authorized by his/her spouse and/or other adult dependents to disclose and receive information about them that is used solely for these purposes
- hereby acknowledge and agree that my/our or my dependents' personal information may be exchanged only between Alberta Blue Cross and a licensed physician and/or other health care professional, practitioner, institution or health benefits provider or insurer and only when needed for a purpose stated above
- understand that my/our and my dependents' personal information will be kept confidential and secure.
- understand that I/we may revoke this consent at any time and acknowledge that should I/ we do so, my/our claim may not be considered
- understand why my/our and my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its use as described above
- have read and understood this Acknowledgement and Consent
- authorize Alberta Blue Cross to collect, use and disclose my/our and my dependents' personal information as described above
- agree that this consent shall be effective from the date of claim and shall remain in effect as long as the coverage is in force.

Signature of Subscriber

Date

Signature of Patient/Claimant (or Parent/Guardian)

Date

*This consent is obtained in accordance with Alberta's *Health Information Act* and *Personal Information Protection Act* and the federal Personal Information Protection and Electronic Documents Act.
**I/we – refers to the one or more individuals signing and/or submitting this form.

PLEASE SEE REVERSE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

SEND THIS CLAIM WITH YOUR ORIGINAL RECEIPTS TO ALBERTA BLUE CROSS, HEALTH SERVICES, 10009 - 108 STREET NW, EDMONTON AB T5J 3C5