Equitable Life of Canada®

Head Office
Group Health Claims Department
One Westmount Road North
P.O. Box 1604 Stn. Waterloo, Waterloo Ontario N2J 0A7
TF 1.800.265.4556 **T** 519.886.5210

SUPPLEMENTARY HEALTH BENEFITS CLAIM FORM

PLAN MEMBER'S LAST NAME | GIVEN NAMES

ADDRESS | POLICY NUMBER: 812425

APT. | CITY | PROV.

POSTAL CODE | TEL. NUMBER

NAME OF EMPLOYER: IBEW Local 258 Electrical Workers Health & Welfare

DIVISION (IF APPLICABLE)

CERTIFICATE/I.D. NUMBER | DATE OF BIRTH

DRUG EXPENSES

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd / mm / yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$

OTHER EXPENSE (Excluding Drugs)

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd / mm / yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Amount Charged For Each Expense	Date of Visit or Purchase (dd / mm / yyyy)	Type of Expense
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
TOTAL OF ALL DRUG AND OTHER						**$**		

IF YOU HAVE A HEALTH CARE SPENDING ACCOUNT (HCSA) please complete the following.

To ensure you maximize your benefit coverage, review any coverage you have through any provincial health insurance or private plan and claim accordingly. A private plan may include benefit coverage you and/or your dependents have through another insurance carrier. You may find it useful to review the Coordination of Benefits provisions in your Plan Member booklet/brochure.

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ I want my eligible expenses paid from my Equitable Life health or dental plan ONLY.

☐ I want my eligible expenses paid from my Equitable Life health or dental plan FIRST and my unpaid portions of my eligible expenses paid from my HCSA.

☐ I want ALL my eligible expenses paid directly from my HCSA.

Please note: If you do not select any of the above options, no portion of this claim will be paid from your Health Care Spending Account (HCSA)

PLEASE COMPLETE NEXT PAGE

Equitable Life of Canada®

SUPPLEMENTARY HEALTH BENEFITS CLAIM FORM

PLEASE ANSWER ALL QUESTIONS. This claim will be returned to you if it is incomplete or contains errors.

1. Are medical benefits also provided through another Group Insurance Plan? Yes ☐ No ☐

If "Yes" complete the following information about the person who is the member under the other plan.

MEMBER'S NAME _____ CERT/I.D. NUMBER _____ DATE OF BIRTH _____

INSURANCE COMPANY'S NAME _____ POLICY PLAN # _____

If the health coverage under another group insurance plan has been cancelled, please give cancellation date _____/_____/_____ (day / month / year)

If the Group Insurance Plan mentioned in this question is an Equitable Life plan and inforce, do you want us to coordinate benefits? Yes ☐ No ☐

2. Are claims being submitted as a result of an accident? Yes ☐ No ☐ If "Yes" give date, location and explain how accident happened.

3. Are any expenses related to an illness/injury that is work related? Yes ☐ No ☐

AUTHORIZATION AND CERTIFICATION

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing, adjudication, investigation, and the detection and prevention of fraud and claims abuse. I understand and authorize that for the above purpose the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, any industry drug pooling entity, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including but not limited to pharmacies, physicians, dentists and practitioners, medical suppliers, regulatory bodies, government organizations, and my Plan Sponsor.

Should Equitable Life pay or reimburse any claim in an amount that exceeds the benefit amount under the Group Insurance Policy, or should such payment or reimbursement result from the claimant's misrepresentation, claims abuse, fraud, falsification or tampering with claim documents or receipts, or the claimant not actually receiving the goods or services claimed (the "Overpayment"), I acknowledge and agree that: (a) I am indebted to Equitable Life in the amount of the Overpayment; (b) Equitable Life is entitled to recover the Overpayment through any means available by law; (c) Equitable Life will apply and offset any benefit payments and reimbursements against the Overpayment until Equitable Life has recovered the Overpayment in full; and, (d) in the case of misrepresentation, claims abuse, fraud, falsification or tampering with claim documents or receipts, or the claimant not actually receiving the goods or services claimed, your Group Benefits coverage may be immediately terminated by Equitable Life. I consent to Equitable Life providing such information and documentation regarding the misrepresentation, claims abuse, fraud, falsification or tampering with claim documents or receipts to my employer/plan sponsor for the purpose of my employer/plan sponsor understanding the reason for the termination of my Group Benefits coverage and for the purpose of my employer/plan sponsor conducting its own investigation into the reason for the termination of my Group Benefits coverage.

If you are submitting your claim form electronically (visit www.equitablehealth.ca for more details)

☐ **Click to confirm and acknowledge your agreement with the above;**

OR

If you are printing your claim form to mail it to Equitable Life, provide your written signature to confirm and acknowledge your agreement with the above:

Plan Member Signature _____ **Date** _____

Falsifying or tampering with claim documents/receipts could have legal consequences.

CLAIM SUBMISSION INSTRUCTIONS – Please keep a copy of your claim form and receipts for your own records.

Electronic Submission - Visit www.equitablehealth.ca or www.equitable.ca and use our EZ Claim™ online feature to submit your Health claim, along with your receipts and supporting documentation. This is a secure and confidential portal for claim submission.

Please NOTE: While using the internet and email is convenient, sending confidential and personal information through the Internet is not secure. Email is vulnerable to interception. Equitable cannot ensure the privacy of information sent by email.

Mailing Instructions: Mail your completed and signed form to our Health Claims department. Attach all receipts and supporting documentation. Please do not use staples.

Equitable Life of Canada; Attn: Group Health Claims Department
One Westmount Road North
P.O. Box 1604 Waterloo, Waterloo Ontario N2J 0A7