

4. Claim Details

4.1 Was this expense incurred while travelling on business? Yes No

4.2 Departure date from province: 4.3 Return date to province:

4.4 This claim is due to: Injury Sickness Describe how and where it happened:

4.5 When did injury occur or symptoms of sickness first appear?

4.6 Where did injury occur or symptoms of sickness were first noted (city/country)? _____

4.7 Have you had same or similar condition before? Yes No If yes, when? _____

If "Yes", provide details.

4.8 Were you hospitalized for your present condition? Yes No If "Yes", please provide the following:

Name and address of hospital: _____

Dates of hospital confinement:

From to | From to

4.9 Name and address of your family doctor in Canada.

Name: _____ Telephone: _____

Address: _____

5. Schedule of Expenses (if space is insufficient, please continue on a separate sheet of paper)

Important – Send original copy of receipts or invoice (Keep copies for personal records. Originals will not be returned.)

Date of Service	Claimed services	Name of Provider	Total Bill*	Country and Currency	Has Account Been Paid?		Paid By Provincial Health Plan	Paid by Other Insurance Carrier
					Yes	No		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
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<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
Totals								

6. Remit payment to provider (To be completed by the participant if cheque is to be made payable to the Provider)

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

Signature of Participant

Date

Telephone Number