

1. IDENTIFICATION OF PARTICIPANT

As indicated on your insurance certificate

Group No.	Identification No.
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or

Policy No.

Last name	First name
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Check all the appropriate boxes

This claim concerns the: Participant Spouse Child(ren)

Complete this section only if your contact information has changed

NEW ADDRESS ONLY		
No., Street	Apartment	
City	Province	Postal code
Telephone (home)	Telephone (work)	Telephone (cell)

IMPORTANT

- ➔ Please enclose your **original receipts** with this form and send the documents to the address indicated at the top of this form.
- ➔ Please keep a copy of your receipts, as the originals **will not be returned**.
- ➔ You must submit your claim for benefits **within 12 months following the date** on which the expenses were incurred and the services were rendered.
- ➔ To speed up processing of your claims, please provide us with **the information requested**.

Are the expenses claimed on this form the result of:

- a **work-related injury** Yes No
- an **automobile accident** (as defined by the SAAQ)? Yes No

If so, you must first submit your claim to the CSST or the SAAQ.

Name of the accident victim

Date of the accident (YYYY/MM/DD)

2. INFORMATION ABOUT THE DEPENDENTS – Complete this section if you are submitting a claim for a dependent.

Spouse

Last name

First name

Date of birth (YYYY/MM/DD)

Dependent children Last name, first name	Date of birth (YYYY/MM/DD)	Full-time student	Complete this section if you are submitting a claim for a child over age 17 or 20, depending on your group insurance contract	
			Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD)
		<input type="checkbox"/>		
		<input type="checkbox"/>		
		<input type="checkbox"/>		
		<input type="checkbox"/>		

La Capitale Civil Service Insurer Inc. reserves the right to ask you for written proof from the institution attended at any time

3. CLAIMED EXPENSES

Refer to your booklet for details of eligible expenses. Attach your original receipts.

	Prescription drug expenses	Other Expenses	TOTAL
Total amount of your receipts	\$	\$	\$

4. COORDINATION OF BENEFITS – Complete this section if the expenses incurred are covered under another insurer's plan.

How to make a claim when there are two insurers:

- Your spouse first submits his or her claim to his or her insurance company; then, your spouse submits details of the benefits paid and photocopies of the receipts to La Capitale Civil Service Insurer Inc.
- Claims for dependent children are submitted to the insurance company of the parent whose birthday falls first in the year.

Type of coverage: Individual Couple Single-Parent Family

Name of insurer

Insurance start date (YYYY/MM/DD)

5. HEALTH SPENDING ACCOUNT – Complete this section if this coverage is indicated on your service card.

Do you want any unpaid portion of your claimed expenses to be considered under your Health Spending Account? Yes No

6. DIRECT DEPOSIT – Complete this section if you wish to register for or modify your account.

La Capitale Civil Service Insurer Inc. prefers to reimburse expenses by direct deposit. It is a **fast, easy** and **secure** way to receive your benefits **directly**. To register for or modify your account, **please enclose a cheque specimen marked "Void" or any other acceptable document**.

- I hereby authorize La Capitale Civil Service Insurer Inc. to deposit my healthcare benefits into my bank account indicated on the enclosed document.
- Direct deposit account change, if already enrolled.

X

Participant's signature

Date (YYYY/MM/DD)

7. PARTICIPANT'S DECLARATION

- I declare that all the information provided in this claim is true and complete. I authorize any person associated with this claim to disclose any relevant information to La Capitale Civil Service Insurer Inc.

X

Participant's signature

Date (YYYY/MM/DD)