La Capitale

Claim

for prescription drug and for medical and paramedical expenses

La Capitale Insurance and Financial Services Inc.
Delta 3 Building, 2875 Laurier Blvd
Suite 400, P.O. Box 1500 Quebec QC G1K 8X9

Need some help in completing this form?
Call us at 418 644-4200 or 1 800 463-4856.
You can download a printable version of this form from La Capitale's website at
lacapitale.com/groupforms

IMPORTANT

- Please enclose your **original receipts** with this form and send the documents to the following address:
  La Capitale Insurance and Financial Services Inc.
  Delta 3 Building, 2875 Laurier Blvd
  Suite 400, P.O. Box 1500 Quebec QC G1K 8X9
- 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.
- **Any failure to provide information or any inaccuracy in the information provided** will result in a processing delay and may result in our returning the claim to you.

1. IDENTIFICATION OF PARTICIPANT

As indicated on your insurance certificate

Group No. | Employer No. | Identification No.

Check all the appropriate boxes

This claim concerns the: ☐ participant ☐ spouse ☐ child(ren)

2. INFORMATION ABOUT THE PARTICIPANT

☐ Male ☐ Female

Last name _____ First name _____

Home address

No., Street _____ Apartment _____

City _____ Province _____ Postal Code _____

Telephone (home) _____ Telephone (work) _____

☐ Indicate whether your **address has changed** since the time of your last claim.

IMPORTANT

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) _____

Continued on reverse

3. 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 and 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.		
			Name of educational institution	Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD)
		☐			
		☐			
		☐			
		☐			

IMPORTANT La Capitale Insurance and Financial Services Inc. reserves the right to contact the educational institution to obtain confirmation of student status.

4. CLAIMED EXPENSES

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

IMPORTANT: The originals will not be returned.

	Prescription drug expenses	Equipment and appliance expenses	Medical and paramedical expenses	Vision care expenses	TOTAL
Total amount of your receipts	$	$	$	$	$

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

The following process applies when both spouses have insurance coverage:

a) Both spouses first submit their claim to their own insurance company; then, they submit details of the benefits paid and photocopies of the receipts to La Capitale Insurance and Financial Services Inc.;

b) Claims for dependent children are submitted to the insurance company of the parent whose birthday falls first in the year.

Name of insurer _____ Policy No. _____

Type of coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

6. HEALTH SPENDING ACCOUNT – Complete this section if you have a Health Spending Account under your group insurance contract.

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

7. DIRECT DEPOSIT AUTHORIZATION

La Capitale Insurance and Financial Services Inc. prefers to reimburse expenses by direct deposit. It is a **fast**, **easy** and **secure** way to receive your benefits **directly**. If you have not yet signed up for direct deposit service, **complete the following section to enrol**.

☐ **I hereby authorize La Capitale Insurance and Financial Services Inc. to deposit my healthcare benefits into the bank account indicated on the enclosed cheque specimen or into the bank account identified below.**

☐ **Direct deposit account change, if already enrolled.**

X _____

Participant's signature _____ Date (YYYY/MM/DD) _____

IMPORTANT Please enclose a cheque specimen marked "VOID" from the designated financial institution, or complete the section below.

Transit No. _____ Institution No. _____ Account No. _____

8. 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 Insurance and Financial Services Inc.

X _____

Participant's signature _____ Date (YYYY/MM/DD) _____