

INFORMATION ON THE PARTICIPANT

If the information contained in Section A is incorrect or incomplete, please fill in Section B.

A.

B.

Name: _____

Address: _____

Group: _____ Employer: _____

Identification No.: _____

Postal Code: _____ Phone No.: _____

Group: _____ Employer: _____

Identification No.: _____

IMPORTANT 1. Enclose only the original invoice indicating the name of drug, dosage, and quantity. Keep any copies because the original will not be returned.
 2. For dependent child aged 18 to 26 years old, fill in section 2 of this form.
 3. Your claim form must be filled in within 12 months from the date medical expenses were incurred and services received.

1- HEALTH CLAIM FOR PRESCRIPTION DRUGS

Prescription drugs purchased for:	Name	First name	Date of birth
Spouse	_____	_____	Y M D
Participant <input type="checkbox"/>	_____	_____	Y M D
Dependant children	_____	_____	Y M D
	_____	_____	Y M D
	_____	_____	Y M D

Total purchase of prescription drugs: _____ \$ Total purchase of other expenses (on reverse): _____ \$

Are any health benefits or services provided under any other group insurance? No Yes

Family coverage Individual coverage Single parent coverage

If yes, policy no.: _____ Name of insurer: _____

Note: Declaration and signature compulsory on reverse side.

2- STUDENT CERTIFICATE FOR CHILD AGED OVER 17 OR 20 YEARS OLD ACCORDING TO YOUR POLICY

I hereby certify that my child _____ is unmarried and attends the secondary school, college or university _____ for the fall session _____, or winter session _____, as a day student on a full time basis.

First name
Name of Institution
Year

