

Canadian Health Insurance Plan Services (C.H.I.P.S.)

Claim for Extended Health Benefits

IMPORTANT:

For consideration of benefits, your claim form must be completed in full.

- Attach **original** accounts/receipts to this form. Photocopies, carbon copies, credit card receipts or cash register receipts are not acceptable.
- For drug claims, prescription number and name of drug or D.I.N. (Drug Identification Number) must be shown on all receipts.
- Claims for this calendar year must be submitted by June 30th of the following calendar year.
- Incorrect or incomplete information will delay payment.
- All information recorded on this form is confidential

MEMBER INFORMATION

Full Name				Name of Worksite / Employer	
Date of Birth (XXza a žmmm)	Group #	Division #	Certificate #	Fair Pharmacare Registration #	

COORDINATION OF BENEFITS

Are you or any other members of your family entitled to benefits under any other plan? Yes No

Are you, or is your family, registered with Fair PharmaCare? Yes No

Are you seeking damages from a third party? Yes No

If "Yes", name of family member insured _____

Relationship to Member _____

Name of other insurance company _____

Policy Number _____

Is any member of your family (other than yourself) insured as a Member under this plan? Yes No

If "Yes" to either question above, and the patient is a dependant child, please provide spouse's date of birth _____ / _____

Day / Month

Note: Charges for dependant children must first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year

DEPENDANT INFORMATION

Patient Name	Relationship to Member	Does patient reside with you?	Full-Time Student?	If Child over 18 years	
				Employed?	How many hours worked per week?

CLAIM DETAILS

Patient Name	Date of Birth (dd,mm,year)	Is this an ICBC, or other auto insurance, case?	Is this a WCB case?	Total Expenses
Total:				

I authorize the release of any information requested in respect of this claim to the Insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge. I hereby authorize the use of my Social Insurance number and any claim information for the administration of the benefits under this group policy.

DATE (dd,mm,year):

SIGNATURE OF INSURED:

Return Address <i>print clearly</i>	Canadian Health Insurance Plan Services (C.H.I.P.S.) c/o Mohart Insurance Consultants Ltd. P.O. Box 3096, Langley, B.C. V3A 4R3 Phone: (604) 533-5144 Toll Free: 1-800-883-7526
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