

HEALTHCARE CLAIM FORM

You may fill out the form online and print it or print the form and fill it out by hand.

EMPLOYEE STATEMENT							
Group Contract Number Certificate Number							
Employer							
Employee Last name and given name							
Date of Birth: day / month / year Sex F □ M □							
Employee Address:							
WOULD YOU LIKE YOUR CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT? Yes , I am attaching a void cheque in order to benefit from that service. Once you have provided a void cheque, only send another void cheque if you change your bank information.							
COORDINATION OF BENEFITS							
Does your spouse and/or children have coverage under any other medical plan or contract? □ Yes □ No If yes, please complete the following: Spouse's date of birth (D/M/Y) Insurance company, policy number and certificate number							
2. Is any expense the result of an accident? □ Yes □ No If yes, please complete the following: Date Location of accident Work □ Home □ Other □ Explain how the accident occurred							
3. If this claim is for a child 21 years of age or older, please indicate the following: Is the child handicapped □ Is the child a full time student □							
DRUGS, VISION CARE, PARAME		L SER		AND OTHERS - PATIENT	INFORMATION		
Patient's name (Use one line per patient)	Day	Month	Year	Relationship to plan member	Total charge	REMINDER	
]	
	<u> </u>					PLEASE REFER TO YOUR EMPLOYEE SUMMARY OF	
						BENEFITS TO CONFIRM THE AMOUNT OF TIME YOU HAVE TO SUBMIT A CLAIM.	
						THIS FORM MUST BE	
						COMPLETED IN FULL. INCOMPLETE FORMS	
						WILL BE RETURNED TO YOU, WHICH WILL	
PRESCRIPTION DRUGS TOTAL FEE SUBMITTED DELAY THE PROCESSING OF THE CLAIM.							
Please attach your original receipts to the back of this form. All drug receipts must contain the drug identification and the name of the prescription drug.							
VISION CARE - ASSIGNMENT OF BENEFITS							
Name and address of provider:				, , , , , , , ,	I hereby assign my benefits payable from this claim to the named provider and authorize payments directly to him/her.		
PRO							
Telephone:				Signature of employee		Date	
AUTHORIZATION							
Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my certificate number as an identification number where it is required in the administration of my group benefit plan. I authorize Cowan, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Cowan to exchange information when necessary to assess my claim and to administer the group benefit plan.							
I certify that the information given is true, correct and complete to the best of my knowledge.							
Signature of employee Date							
MAIL YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:							
Cowan Insurance Group							

Cowan Insurance Group 700-1420 Blair Place Ottawa, Ontario K1J 9L8 Telephone: 1-888-509-7797 or 1-613-741-3313