



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

1. 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, PARAMEDICAL SERVICES AND OTHERS - PATIENT INFORMATION

Table with 5 columns: Patient's name, Date of birth (Day, Month, Year), Relationship to plan member, Total charge, and REMINDER. Includes a 'TOTAL FEE SUBMITTED' row and a 'PRESCRIPTION DRUGS' section.

VISION CARE - ASSIGNMENT OF BENEFITS

Name and address of provider: \_\_\_\_\_ Telephone: \_\_\_\_\_
I hereby assign my benefits payable from this claim to the named provider and authorize payments directly to him/her.
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 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
700-1420 Blair Place
Ottawa, Ontario K1J 9L8
Telephone: 1-888-509-7797 or 1-613-741-3313