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# MAJOR MEDICAL EXPENSES STATEMENT

| Plan Member's Full Name | Group or Employer | Personal Identification No. |
|---|---|---|
| | Seneca Polytechnic | Group # 100003 I.D N |
| | | Date of Birth Day / Month / Year |

Street _____ Apt. _____ ❑ English ❑ French

City _____

Province _____ Postal Code _____

## COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

| Dependent's name (Last, First) | Date of Birth | | | Relationship to Plan Member | If this claim is for a dependent child aged 21 or over, please indicate the most recent date on which the memeber qualified as a full-time student | | | |
|---|---|---|---|---|---|---|---|---|
| | Day | Month | Year | | Name of School | Day | Month | Year |
| | | | | Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____ | | | | |
| | | | | Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____ | | | | |
| | | | | Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____ | | | | |
| | | | | Spouse ❑ Daughter ❑ Son ❑ Other (describe) _____ | | | | |

## EXPENSES (OTHER THAN DRUGS) – (Attach original receipts and list below)

| Nature of expense | Date incurred | Recommended by: Physician's name | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? ❑ Yes ❑ No

2 a. If yes, indicate member under other plan: ❑ Self ❑ Spouse

2 b. Name of other insuring agency or plan _____

Policy No. _____ Certificate No. _____

Total Claim $

Name _____ Date of Birth Day Month Year

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.
I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Date _____ _____

ClaimSecure
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