

**MAJOR MEDICAL EXPENSES STATEMENT**

Plan Member's Full Name	Group or Employer CAMBRIAN COLLEGE	Personal Identification No. Group # 514051 I.D. B Date of Birth _____ Day / Month / Year						
Street _____ Apt. _____ City _____ Province _____ Postal Code _____ ☐ English ☐ French								
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 member 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. _____		
Name _____ Date of Birth _____ Day Month Year						Total Claim \$		

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
PO Box 6500, STN A
Sudbury, ON P3A 5N5