EXTENDED HEALTH BENEFITS (EHB) CLAIM FORM

1. Personal information (Please be sure to complete all fields in this section)

Group policy, Division and Certificate no.	Name of Employer		Email address
Insured employee's name		Date of birth (mm/dd/yyyy)	Telephone
Address		City	Prov / Postal Code
Is claim being made for Worker's Compensation Benefits? O yes O no	If treatment was required because of an accident, how did it happen?		Date of accident (mm/dd/yyyy)

Do you, your spouse or dependant(s) have any other Extended Health Insurance under which the expenses being claimed are eligible? O yes O no (If yes, please complete the next two lines)

Name of Policyholder	Date of birth (mm/dd/yyyy)
Name of other insurance company	Group policy and Certificate no.

2. **In order to process a claim**, the original receipt(s) must be attached.
If Empire Life is the second payer, include a photocopied receipt and original Explanation of Benefits from the first payer with your claim form. Retain copies of your original receipts for your records.
Drug claims must include an original "Official Prescription Receipt" from the pharmacist.

Some group plans may have elected to include the Incidental Health Expense Benefit (IHE) as an optional component to their Extended Health Benefits. If your plan does not include this option, disregard the IHE questions in section 3, and complete the remainder of the form.

3. Claim Summary - All of this claim to be paid for through IHE? O yes O no

Patient name	Date of purchases or services rendered	Name of drug or type of service	Charged amount	Balance paid through IHE?
				O yes O no
				O yes O no
				O yes O no
				O yes O no
				O yes O no
				O yes O no
				O yes O no

4. **I certify** that the statements above are complete and true and that none of the attached receipts duplicate previously submitted charges.
I authorize the relevant physicians, hospitals and other service providers to release full information and records with respect to this claim to The Empire Life Insurance Company (Empire Life) and I authorize Empire Life, its agents, representatives, consultants, other insurance companies and reinsurers to collect and review this information (as deemed necessary) for the purpose of reviewing, assessing and managing this claim. I understand information pertaining to this claim may be reviewed in the event the plan is audited;
I agree a photocopy of this authorization shall be as valid as the original.
I understand that Empire Life may exchange information about these claims with me or any person acting on behalf of myself or the person for whom I am making the claim (as deemed necessary) for the purpose of confirming eligibility and assessing and managing the claim. If I have provided information about another person, I confirm that I am authorized to provide such information.

Signature of insured employee X	**Date** (mm/dd/yyyy)

5. Direct Deposit (For first request or if making a change, please include a voided personal cheque)

O Register me O Change my details O Use my info on file	Group Policy, Division and Certificate no.

Empire Life

IMPORTANT INFORMATION

Serving you promptly

For prompt payment of your claim, please be sure to include the following:

- ❍ A completed and signed claim form, including your address and postal code.
- ❍ Original receipts (If Empire Life is the second payer, include a photocopied receipt and original Explanation of Benefits from the first payer with your claim form).
- ❍ The Explanation of Benefits from your other insurance company, if you are coordinating benefits.
- ❍ A voided personal cheque if you are signing up for our convenient electronic funds transfer (EFT) or making a change to the personal information we have on file regarding your existing EFT.

Please note that:

- ❍ Missing or incorrect information may result in a delay in your payment.
- ❍ Empire Life may ask for additional information in order to assess this or any future claims. Payment of this claim does not indicate future claims for these items or services will be approved.
- ❍ Claims submitted more than 365 days after the date of service or more than 90 days after termination of coverage will be declined as too late to allow.

Protecting your privacy

At Empire Life, we recognize and respect the importance of privacy. Personal information we collect will be used to assess your claim and administer the group benefits plan.

Preventing insurance fraud

Insurance fraud is an intentional act or omission with a view to illegally obtaining an insurance benefit. Fraudulent claims increase the cost of your group insurance. In the event there is evidence of fraud and/or plan abuse, this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable the plan sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

Answering your questions

You can count on our Customer Service Unit for prompt and personal service when you have a question or concern. Please call our toll-free number 1 800 267-0215, Monday to Friday, 8a.m. – 8p.m Eastern time, our fax is 1-855-619-0828, or email us at group.csu@empire.ca. Our web address is www.empire.ca.

When completed, please mail your claim form to:

(Fold for window envelope)

The Empire Life Insurance Company
Group Health Claims
259 King St East
Kingston ON K7L 3A8