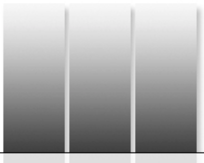

HEALTHCARE EXPENSES STATEMENT

INSTRUCTION: Attach the bills and original receipts for all expenses and itemize them by providing all the information requested. Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax Purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors

Please Print

PART 1: EMPLOYEE'S STATEMENT

PLAN NUMBER	DIVISION NO.	EMPLOYER NAME

CERTIFICATE NUMBER	EMPLOYEE NAME

ADDRESS: NUMBER AND STREET	CITY	PROVINCE	POSTAL CODE	PHONE NUMBER HOME: WORK:

COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan?

☐ Yes ☐ No

If "Yes", name of family member insured ________________________________

Relationship to employee ________________________________

Name of other insurance company ________________________________

Policy Number ________________________________

Is any member of your family (other than yourself) insured as an employee under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's

Date of birth (d/m/y): ____________________

SEND THIS CLAIM TO:

JSJ Insurance & Financial Group Inc.
195 King St. Suite 208
St. Catharines, ON L2R 3J6
Phone: 905-688-3224

DEPENDENT INFORMATION				If child over 18 years
Patient Name	***Relationship To Employee***	***Birthdate*** (dd/mm/yyyy)	***Full Time Student***	***Name of School/College/University***
			Yes ☐ No ☐	
			Yes ☐ No ☐	
			Yes ☐ No ☐	
			Yes ☐ No ☐	
			Yes ☐ No ☐	

CLAIMANT DETAILS	**EXPENSES**			
Patient Name	Type of Expense	Nature of Illness / Service	Number of Receipts	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

I authorize release of any information or record requested in respect of this claim to JSJ Insurance & Financial Group Inc. and certify that the information given is true, correct and complete to the best of my knowledge. Personal information we collect from you will be used to determine your entitlement to benefits under this plan.

SIGNATURE OF EMPLOYEE ________________________________ DATE ____________________________