SASKATCHEWAN BLUE CROSS®

EXTENDED HEALTH BENEFITS & SPENDING ACCOUNTS CLAIM FORM

516 Second Avenue North PO Box 4030 Saskatoon SK S7K 3T2
Telephone 306.244.1192 or 1.800.667.6853 Fax 306.652.5751 sk.bluecross.ca

PLEASE NOTE

1. This form is to be used for in-province claims only. For any emergency claims incurred outside your province of residence, complete an ***Out of Province Benefits Claim Form***.
2. Attach **original receipts** for each expense claimed and keep copies for your records. **Original receipts will not be returned**. If you claimed these expenses under another plan, submit the original statement along with copies of your receipts.
3. Submit the completed form Attention: Claims Department.

Total number of receipts submitted _____

MEMBER INFORMATION (please print)

Policy Number | ID Number/BC Number | Date of Birth YYYY/MM/DD

First Name | Last Name

Street Address/Box No.

City or Town | Postal Code | Email Address

Has your address changed in the past year? ☐ Yes ☐ No

Mobile Phone Number | Work Phone Number | Home Phone Number

CLAIMANT INFORMATION

First Name	Last Name	Relationship to Member	Date of Birth YYYY/MM/DD	Full-time Student?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

OTHER COVERAGE

Do you or any of your dependents have other coverage under any other Plan? ☐ Yes ☐ No **If Yes, please complete the following.**

Name of Insurance Company | Member Name | Date of Birth YYYY/MM/DD

Plan Number | ID Number | Effective Date

Type of Coverage ☐ Employer Plan Employer Name _____ ☐ Private Plan

Benefits ☐ Drugs ☐ Vision ☐ Other Health ☐ Dental ☐ All If you require assistance in coordinating your benefits, please contact our office.

If you had other coverage that has been cancelled, please provide the cancellation date. _____

SPENDING ACCOUNTS (if applicable)

Please apply the attached receipts or any outstanding amount from this claim to my:

☐ **Health Spending Account** *I understand that I am responsible for payment of any taxes that may arise from reimbursement of these expenses.*

☐ **Wellness Spending Account** *I understand that reimbursement of these expenses is considered taxable income, subject to statutory deductions.*

MEMBER STATEMENT

I confirm that the information I have provided is true, correct and complete to the best of my knowledge. I certify that I am claiming expenses that were incurred by myself or dependent(s) for whom I am entitled to claim a medical expense credit under the *Income Tax Act*. I understand that personal information is collected, used and disclosed to confirm the accuracy of this claim, to administer the terms of the applicable insurance policy, to manage the business of Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross®), and to develop and recommend suitable Blue Cross products and services. I consent to the use of this information for the above purposes in accordance with the privacy policy of Blue Cross (available online at www.sk.bluecross.ca or by calling 1.800.667.6853). I understand I am able to revoke my consent at any time.

Name of Member/Claimant (please print) | Signature of Member/Claimant

Date

®Saskatchewan Blue Cross and Blue Cross are registered trade-marks of the Canadian Association of Blue Cross Plans, used under licence by Medical Services incorporated, an independent licensee. *Trade-mark of the Canadian Association of Blue Cross Plans. †Trade-mark of the Blue Cross Blue Shield Association.

MSI 77 - 30M - 09-16