BLUE CROSS™ OF CANADA

CANADIAN PACIFIC CLAIM FORM FOR EXTENDED HEALTH CARE PLAN FOR PENSIONERS/RETIREES

ALL THE INFORMATION GIVEN ON THIS FORM IS CONFIDENTIAL

MEMBERS

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E1C 8L3
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Subscriber's Name			
Street	Apt.	Group No.	Pensioner No. (Certificate No.)
City & Prov.			
Postal Code			

Dependent section (to be completed if claim includes any expense for a dependent(s).) — Proof required if student or handicapped.

Given name	Relationship: spouse	son	daughter	Date of birth: day	month	year	Dependent child age 21 or over: student	handicapped	Name of school, college or university being attended
1	☐	☐	☐				☐	☐	
2	☐	☐	☐				☐	☐	
3	☐	☐	☐				☐	☐	
4	☐	☐	☐				☐	☐	

* PLEASE FILL OUT THIS FORM AND ENCLOSE ORIGINAL COPIES OF YOUR BILLS AND RECEIPTS. **THESE DOCUMENTS WILL NOT BE RETURNED. DUPLICATES SHOULD BE RETAINED FOR YOUR FILE.**
* PLEASE SUBMIT YOUR CLAIM, AT THE LATEST, MARCH 31st FOLLOWING THE CALENDAR YEAR IN WHICH THE EXPENSES HAVE BEEN INCURRED (UNLESS OTHERWISE STIPULATED IN YOUR CONTRACT).
* PLEASE SEND THE COMPLETED FORM TO THE BLUE CROSS OFFICE SERVING THE PROVINCE IN WHICH YOU RESIDE. THE OFFICES ARE LISTED ABOVE.

ARE EXPENSES SUBMITTED COVERED BY ANY OTHER INSURANCE CONTRACT? ☐ YES ☐ NO

IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ☐ YES ☐ NO

IF YES : _____ _____
CONTRACT NO. INSURER'S NAME

N.B. : THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT HIS CLAIM TO HIS INSURER. AFTERWARDS, PROVIDE BLUE CROSS WITH A COPY OF YOUR RECEIPTS WITH A DETAILED ACCOUNT OF BENEFITS PAID. FURTHERMORE, CLAIMS FOR CHILDREN MUST BE SUBMITTED TO THE INSURER OF THE PARENT (FATHER OR MOTHER) WHOSE BIRTHDAY OCCURS FIRST IN THE CALENDAR YEAR.

I CERTIFY THAT THE EXPENSES SUBMITTED WERE INCURRED FOLLOWING AN ILLNESS OR AN INJURY AND THAT MY STATEMENTS ARE TRUE AND COMPLETE. FURTHERMORE, I AUTHORIZE BLUE CROSS TO OBTAIN FROM THE MEDICAL PRACTITIONER AND / OR MEDICAL CENTRE ALL PERTINENT INFORMATION RELEVANT TO THIS CLAIM.

DATE	SIGNATURE	S.I.N.	( ) TELEPHONE NO.