SASKATCHEWAN BLUE CROSS®

516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

HEALTH BENEFITS & SPENDING ACCOUNTS CLAIM

Total number of pages attached: _____

PLEASE NOTE:

- For expenses related to a medical emergency while travelling outside your province of residence, complete a Travel Insurance Claim Form, available at **sk.bluecross.ca/forms**.
- For expenses related to a motor vehicle accident or workplace injury, submit to your automobile insurance or the WCB for initial benefit consideration.
- This form should be accompanied by itemized receipts or invoices, which indicate the patient's name, the date(s) of purchase/service, description of the product/service, name and location of the supplier/provider and the amount charged. If expenses have been claimed under another source of coverage, a detailed Explanation of Benefits (EOB) statement from their benefit consideration must also be included. Based on the type of claim, additional details or documents may be required or requested, such as a physician's prescription.
- Submit the completed form and any accompanying documents to the above address (**Attn: Claims Department**) or via an approved online claim submission method.

MEMBER INFORMATION (PLEASE PRINT)

Policy Number _____ ID/BC Number _____

First Name _____ Last Name _____

Date of Birth (YYYY-MM-DD) _____

Please complete address section only if information has changed.

Street Address/Box No. _____

City/Town _____ Province _____ Postal Code _____

Email Address _____ Mobile Phone Number _____

Work Phone Number _____ Home Phone Number _____

CLAIMANT INFORMATION

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

OTHER COVERAGE

Are any of these claimed expenses the result of a motor vehicle accident or workplace injury? ☐ Yes ☐ No

Do you or any of your covered dependents have other coverage not previously reported, or changes to other coverage previously reported (including cancellation)? ☐ Yes ☐ No

If **Yes,** *please provide the following details. If* **No,** *skip to the* Spending Accounts *section.*

Name of Insurance Company _____

Member Name (First and Last) _____ Date of Birth (YYYY-MM-DD) _____

Policy Number _____ ID Number _____ Effective Date (YYYY-MM-DD) _____

Type of Coverage: ☐ Group Plan (e.g., employer plan) ☐ Individual Plan (e.g., personal plan)

Benefits: ☐ Drugs ☐ Vision ☐ Dental ☐ Other Health ☐ All

If you had other coverage that has been cancelled, please provide the cancellation date: _____ (YYYY-MM-DD)

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.

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

CLAIMANT STATEMENT / ACKNOWLEDGMENT & CONSENT

I acknowledge that my claim is subject to my benefit plan or policy and that the expenses listed in my claim may not be covered by or may exceed the benefits of my benefit plan or policy. I am responsible to my healthcare provider(s) for the cost of the entire treatment or services provided to me. The claim submitted is a true, correct and complete statement of expenses charged to me by my healthcare provider(s) for services rendered. I have not claimed and will not claim these expenses under any other insurance plan or program, unless otherwise indicated in my claim. I agree and am aware Saskatchewan Blue Cross may engage a collection agency to collect any overpayment that occurs during the course of my health benefit claim.

I authorize my healthcare provider(s) to release any information or records requested in respect of this claim to Blue Cross or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

I understand that the personal information I have provided, as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or its agents, may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross and helping to develop and recommend suitable products and services to me.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations and/or its authorized agents/brokers, representatives, licensed physicians and/or any other healthcare professionals, practitioners or institutions, life and health insurers and reinsurers, government and regulatory authorities, the member of any benefit plan or policy under which I am a participant and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed, and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit **www.sk.bluecross.ca** or call 1.800.667.6853. A photocopy of this authorization shall be as valid as the original.

Name of Member/Claimant (Print) _____ Signature of Member/Claimant _____ Date (YYYY-MM-DD) _____