Equitable Life of Canada®

Head Office
Group Health Claims Department
One Westmount Road North
P.O. Box 1604 Stn. Waterloo, Waterloo Ontario N2J 0A7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-health-claims@equitable.ca

SUPPLEMENTARY HEALTH BENEFITS CLAIM FORM

Note: Please use Form 466 PD (Employee Reimbursement Form For Pay Direct Drug Card Claims) if you are submitting a claim for a drug expense when you were unable to use your Pay Direct Drug Card. (This form is available online at www.equitable.ca or on the secure Plan Member Web Services site at www.equitablehealth.ca™.)

PLAN MEMBER'S LAST NAME	GIVEN NAMES	NAME OF EMPLOYER Earl Paddock Transporatation Inc.	
ADDRESS	APT.	POLICY NUMBER	DIVISION (IF APPLICABLE)
CITY PROV.	POSTAL CODE	CERTIFICATE/I.D. NUMBER	DATE OF BIRTH

DRUG EXPENSES

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd mm yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$
	☐ ☐ ☐		☐	☐		$

OTHER EXPENSE (Excluding Drugs)

Patient's Usual Name	Relationship to Plan Member (self / spouse / child)	Date of Birth (dd mm yyyy)	Children only; check if: full-time university or college student	Children only; check if: disabled	Number of Receipts Per Patient	Amount Charged For Each Expense	Date of Visit or Purchase (dd mm yyyy)	Type of Expense
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
	☐ ☐ ☐		☐	☐		$		
TOTAL OF ALL DRUG AND OTHER						**$**		

If you have a Health Care Spending Account (HCSA) please complete the following.

To ensure you maximize your benefit coverage, review any coverage you have through any provincial health insurance or private plan and claim accordingly. A private plan may include benefit coverage you and/or your dependents have through another insurance carrier. You may find it useful to review the Coordination of Benefits provisions in your Plan Member booklet/brochure.

Please select one of the following options:

- ☐ I want my eligible expenses paid from my Equitable Life health or dental plan ONLY.
- ☐ I want my eligible expenses paid from my Equitable Life health or dental plan FIRST and my unpaid portions of my eligible expenses paid from my HCSA.
- ☐ I want ALL my eligible expenses paid directly from my HCSA.

Please note:
If you do not select any of the above options, no portion of this claim will be paid from your Health Care Spending Account (HCSA)

PLEASE COMPLETE NEXT PAGE

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SUPPLEMENTARY HEALTH BENEFITS CLAIM FORM

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

1. Are medical benefits also provided through another Group Insurance Plan? Yes ☐ No ☐

If "Yes" complete the following information about the person who is the member under the other plan.

MEMBER'S NAME	CERT/I.D. NUMBER	DATE OF BIRTH
INSURANCE COMPANY'S NAME		POLICY PLAN #

If the health coverage under another group insurance plan has been cancelled, please give cancellation date _____/_____/_____ (day / month / year)

If the Group Insurance Plan mentioned in this question is an Equitable Life plan and inforce, do you want us to coordinate benefits? Yes ☐ No ☐

2. Are claims being submitted as a result of an accident? Yes ☐ No ☐ If "Yes" give date, location and explain how accident happened.

3. Are any expenses related to an illness/injury that is work related? Yes ☐ No ☐

Authorization & Certification

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, any industry drug pooling entity, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists and any other person or party whom I authorize.

If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

If you are submitting your claim form electronically (visit www.equitablehealth.ca for more details)

☐ **Click to confirm and acknowledge your agreement with the above;**

OR

If you are printing your claim form to email, fax or mail it to Equitable Life, provide your written signature to confirm and acknowledge your agreement with the above:

Plan Member Signature _____ **Date** _____

Falsifying or tampering with claim documents / receipts could have legal consequences.

Claim Submission Instructions – Please keep a copy of your claim form and receipts for your own records.

Electronic Submission - Visit www.equitablehealth.ca or www.equitable.ca and use our EZ Claim™ online feature to submit your Health claim, along with your receipts and supporting documentation. This is a secure and confidential portal for claim submission.

Alternatively, you can scan and email your claim forms, with receipts as attachments, to group-health-claims@equitable.ca or fax your documents to 519.883.7406 or toll free to 1.888.505.4373.

Please NOTE: While using the internet and email is convenient, sending confidential and personal information through the Internet is not secure. Email is vulnerable to interception. Equitable cannot ensure the privacy of information sent by email.

Mailing Instructions: Mail your completed and signed form to our Health Claims department. Attach all receipts and supporting documentation. Please do not use staples.

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