belairdirect.
group benefits

Extended Health Care Claim Form

A. Member Information

Policyholder (first and last name): _____

Claimant: _____

Address: _____

_____

Telephone #: _____

Email: _____

ID #: _____

Group #: _____

Have you set up direct deposit? If not, please enclose a VOID cheque and your payment (as well as future reimbursements) will be made directly to your account.

B. Claim Information

Number of receipts attached: _____ Total amount claimed: $ _____

1. Is this claim the result of a dental accident? ☐ Yes ☐ No

   If yes, please call 1 833 749.1324 for further instruction and a separate claim form.

2. Is this claim the result of an emergency that occurred while travelling outside your province of residence? ☐ Yes ☐ No

   If yes, please call GEM at 1 877 346.1467 so they can open your claim and provide you with next steps.

C. Dependent* Information (including spouse)

Name (First and Last)	Birthdate (dd/mm/yyyy)	Relationship	Gender	Student Status*	School Year

*Dependents age 21 and over are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the school year, the upper limit of the dependent definition age for students or until coverage is terminated. Proof of full-time status may be required at any time.

D. Co-ordination of Benefits

With coordination of benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate the coverage level, single/couple/family, the spouse/dependent may have with another insurance provider.

Name of family member: _____ Coverage: _____

Name of family member: _____ Coverage: _____

I authorize belairdirect, the plan administrator, to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by belairdirect will be kept confidential and, where necessary belairdirect will be exchanging personal information. I authorize the following persons to exchange with belairdirect or each other, any of my personal information in their possession; any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution. I acknowledge that more detailed information concerning how and why belairdirect collects, uses and discloses my personal information is available at www.belairdirect.com. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original. Some of your personal information may be stored and/or processed by one or more service providers outside of Canada. For more information about our policies and practices regarding our use of personal information and of service providers outside of Canada, please contact our Privacy Officer. A full copy of our privacy statement and the contact information of our Privacy Officer is available at www.belairdirect.com.

Member signature: _____ Date signed (dd/mm/yyyy): _____

Please mail completed claim form and COPIES of your receipts to:

belairdirect
PO Box 4295 Stn A
Toronto, Ontario M5W 5X8