

Flexstyle Claim Form

Mail To: Benecaid Health Benefit Solutions Inc. PO Box 1325 Station K Toronto, ON M4P 3J4

Complete section 1. Enter all claims information in section 2. Complete section 3 where applicable. Sign section 4. Mail to Benecaid at the address above. Missing information will result in claims not being adjudicated and this form along with the claims being returned to you without reimbursement. The address fields below are for identification purposes only. Reimbursement cheques and correspondence will be mailed to the address on file.

	Company Name: Group Policy #:								
1. EMPLOYEE INFO	Loot Name	First Name:	First Name:			Client ID:			
	Last Name:	First Name.	First Name:		Client ID:				
	Street Address:				U		PO Box:		
1. E	City:				Province:		Postal Co	de:	
	In order to process a claim the original receipt must be attached (photocopies will not be accepted unless Benecaid is the second payer). If Benecaid is the second payer then a photocopied receipt along with the original explanation of Benefits from the primary payer is required. Retain photocopies of your original receipts for your records.								
2. CLAIMS INFORMATION	Patient's Name (Individual that incurred the expense)	Patient's Date of Birth	Relationship to Employee	(Der	Type of Expense ntal, Drugs, Vision etc)	Date of Service	Amount \$	
		DD MM YYYY				D	D MM YYYY		
		DD MM YYYY				D	D MM YYYY		
		DD MM YYYY				D	D MM YYYY		
		DD MM YYYY				D	D MM YYYY		
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		DD MM YYYY				D	D MM YYYY		
		DD MM YYYY				D	D MM YYYY		
		DD MM YYYY				D	D MM YYYY		
							TOTAL		
	Are you or your spouse covered by another group or supplementary health insurance pla			☐ Yes ☐ No If "Yes" complete the following information:				ollowing information:	
3. COORDINATION OF BENEFITS	Policy Holder Name	Name of Ins	urer		Policy Number		Coverage Type (Single, Family)		
	Are any claims the result of the following: A work related injury? \(\text{Yes} \) \(\text{No} \) A motor vehicle accident? \(\text{Yes} \) \(\text{No} \) If "Yes" complete the following information:								
	Name of Injured	Date of Accid		Is claim being made for Workers Compensation Benefits?					
	Claiming Options (Complete if you also have a Health				☐ Yes ☐ No				
	□ I want ALL attached eligible expenses paid from my Group Health & Dental plan ONLY								
()	□ I want ALL attached eligible expenses paid FIRST from my Group Health & Dental plan with any unpaid balance applied to my Health Spending Account								
ENT	Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the benefit plan.								
	I certify that the answers to the above questions are true to the best of my knowledge and that the enclosed receipts represent a claim for services rendered to me and/or my								
AKNOLEDGEMENT	eligible dependents. If this claim is being made on behalf of my spouse and/or dependent children, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I authorize Benecaid, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Benecaid and its insurance companies to exchange information when necessary to assess my claim and to								
KNOL	administer the benefit plan. A photocopy of this authorization is as valid as the original when obtaining information. I acknowledge that all costs to investigate and validate claims, including doctors notes and fees, are my responsibility and will not be paid or reimbursed by Benecaid.								
4. A	Signature:						Date Signed:	DD MM YYYY	

ASO/22-101-B (01.10) Page 1 of 2



Flexstyle Claim Submitting Instructions

How do I Submit Claims?

In order to be reimbursed for eligible medical and dental expenses the following forms and supporting documentation must be submitted to Benecaid:

Prescription Medication

- · Benecaid Claim Form with original signature
- Original computerized Official Prescription Receipt with Pharmacist signature or stamp

Dental Treatments

- · Benecaid Claim Form with original signature
- Original Standard Dental Claim Form, including the Dentist's signature or stamp

Optical Services

- · Benecaid Claim Form with original signature
- Copy of Original Prescription for Eyeglasses or Contact Lenses
- · Original receipt of payment

Other Services (ie. Chiropractic, Chiropodist, RMT, etc.)

- Benecaid Claim Form with original signature
- Original receipt from the licensed Medical Practitioner, including all the following information:
 - · Practitioner, Address and Phone Number
 - Name of the licensed Medical Practitioner who performed the service
 - License number and credentials of the Medical Practitioner
 - Patient Name
 - Date of Service
 - · Amount of money paid
 - Description of service or treatment including cost per treatment
 - · Signature or stamp of the licensed Medical Practitioner who performed the service

How do I submit a claim when there are two insurers?

When submitting your claims you should send them to the primary carrier first (i.e. you send your claims to Benecaid and your spouse's claims go to their insurance carrier). If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other insurance company with the original Explanation of Benefits (EOB) and copies of the receipts. Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year. If the parents have the same date of birth then the claims will be reimbursed based on alphabetical order of the parent's first name.

If Benecaid is the second payer then a photocopied receipt along with the <u>original</u> Explanation of Benefits from the primary payer is required. If the EOB is for a dental claim, the EOB should contain procedure codes, tooth codes, tooth surfaces and provider information. If the EOB does not contain this information please submit a photocopy of the dental claim along with the EOB.

Should I keep Copies of my Original Receipts?

Always retain photocopies of your original receipts for your records.

Where do I Mail Claims?

All claims and supporting documentation must be mailed to Benecaid at the following address:

Benecaid Health Benefit Solutions Inc. PO Box 1325 Station K Toronto, ON M4P 3J4

ASO/22-101-B (01.10) Page 2 of 2