SASKATCHEWAN
BLUE CROSS®

516 – 2nd Avenue N., P.O. Box 4030 Saskatoon, Saskatchewan S7K 3T2
Tel: (306) 244-2662 Fax: (306) 652-5751

www.sk.bluecross.ca

GROUP EXTENDED HEALTH BENEFITS CLAIM FORM

PLEASE NOTE: TO ENSURE PROMPT HANDLING, PLEASE COMPLETE THIS FORM AND RETURN WITH YOUR NEXT CLAIMS SUBMISSION. (INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR CLAIM)

POLICY NUMBER	IDENTIFICATION NO.	EMPLOYEE'S SURNAME	FIRST NAME	DATE OF BIRTH YR.	MO.	DAY
50427						

STREET/BOX NO.	CITY/TOWN	POSTAL CODE

HOME PHONE NUMBER	WORK PHONE NUMBER(S)
( )	( )

Are any benefits or services being claimed available to you or your dependents from any other group insurance, WCB or Government Plan, or Saskatchewan Blue Cross? If Yes, please complete the following: Yes ☐ No ☐

Name of other insuring agency or plan: _____ Policy Number _____

Please indicate (✓) the type of other coverage: Health: _____ Dental: _____

Spouse's Surname: _____ First Name _____ Spouse's date of birth: Year _____ Month _____ Day _____

I certify that, I have not claimed and will not claim these expenses under any other insurance plan (unless indicated above), and that all information contained herein is correct. I authorize the release by any health care provider, Saskatchewan Blue Cross or any of its agents of any information necessary for the administration of this claim or my group plan. A photostat of this authorization is as valid as the original.

Signature _____ Date _____

IF CLAIMING FOR SPOUSE OR DEPENDENT(S), PLEASE COMPLETE THE FOLLOWING

	RELATIONSHIP TO EMPLOYEE	FIRST NAME	LAST NAME (IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH YR.	MO.	DAY	PROVINCIAL HEALTH #	DEPENDENT INFORMATION If Dependent is 18 and over, please indicate name of full-time educational facility being attended. NAME OF SCHOOL
1	SPOUSE							
2	CHILD							
3	CHILD							
4	CHILD							
5	CHILD							

INSTRUCTIONS ON HOW TO CLAIM

(A) Please complete all sections of this claim form and submit with the *ORIGINAL* itemized receipts/invoices.

(B) All original receipts/invoices must identify the patient's first and last name, type of service, date of service, and amount paid.

(C) If the service being claimed requires a physician's referral, please attach the referral from the physician.

(D) Please retain copies of all receipts, prior to submission, as failure to do so may result in a $20 service fee.

(E) If your plan includes Travel benefits, please refer to your benefits booklet for claiming instructions.

(F) Please mail all information to:

Saskatchewan Blue Cross
Group Claims Department
P.O. Box 4030
Saskatoon, SK S7K 3T2

OR

Saskatchewan Blue Cross
Group Claims Department
100-1870 Albert St.
Regina, SK S4P 4B7

Number of Receipts ☐

(G) General Enquiries:

Saskatoon: 1-306-244-2662 1-800-USE BLUE 1-800-873-2583 Fax: 1-306-652-5751
Regina: 1-306-525-5025 Fax: 1-306-525-2124

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.