MEDICAL CLAIM FORM

Expenses must be submitted within 12 months of the date incurred.

The drug name and **drug identification number (DIN)** must appear on the drug receipts. This information is available from your pharmacist. Group your receipts by family member and attach them to the back of this form. Receipts will not be returned. Your benefit statement is sufficient for tax purposes and for co-ordination of benefits. **All statements must be completed or this form may be returned.** Submit your claim by:

Mail: **MDM Insurance Services Inc. P.O. Box #970, Guelph, Ontario N1H 6N1**
E-mail: **inquiry@mdm-insurance.com** Fax: **519-836-4909**

Privacy Statement
MDM Insurance Services Inc. is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Member's Statement (Print clearly or type)

Name of Plan ***Health Plus*** _____ Group Policy No. _____

Member's Name _____ Date of Birth _____
Last First

Member's Home Mailing Address _____

Patient Name(s)	Relationship to Member	Date of Birth Yr/Month/Day	If child 21 or older: Student Yes	Student No	Employed Yes	Employed No	Handicapped Yes	Handicapped No	If Student Indicate Name of Educational Institution

1. a. Does your spouse have a benefit plan? ❒ Yes ❒ No

b. Name of spouse's insurer _____ Group Policy No. _____ Spouse's date of birth _____

c. If you also have a Health Spending Account, should any unpaid balance of this claim be reimbursed under your Health Spending Account before being considered under your spouse's plan? ❒ Yes ❒ No

If any of the expenses have been paid under any other plan (WSIB, Spouse's Plan, etc.), please include a copy of the benefit statement.

2. a. Please state if any part of this claim has been incurred as the result of an accident. ❒ Yes ❒ No

b. If yes, please supply: Date of accident _____ Name of Patient _____

c. Accident occurred: ❒ At work ❒ Elsewhere Motor Vehicle Accident: ❒ Yes ❒ No

d. Details: _____

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individual(s). I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist, or any health care provider and/or facility, any insurance company, benefit service provider and any other organization having any medical or other relevant personal information regarding me or my spouse and/or dependent(s) to release to and exchange with MDM, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependent(s) for such purposes. Any copy of this authorization shall be as valid as the original.

Date: _____ Signature of Member _____