HEALTHCARE EXPENSE STATEMENT

Belmont Health & Wealth

Submit Completed Form to:
Belmont Health & Wealth
Attention: Claims Department
Suite 605, 133 Prince William St
Saint John, NB E2L 2B5
Phone: (506) 634-7050
Toll Free: (800) 565-7050
Fax: (506) 634-6371

INSTRUCTIONS:

Attach the original bills and receipts for all expenses and itemize them by providing all the information requested. Note: Receipts are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or photocopies of originals for Income Tax purposes.
For Vision Care, please ensure your receipt is detailed and broken down (i.e.) frames, lenses, contacts etc…

IMPORTANT:

Please answer all questions and sign the bottom of this form. This claim will be returned to you unprocessed if it is incomplete or contains errors. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

EMPLOYEE INFORMATION

Policy # 32262

Atlantic Canada Regional Council (ACRC)

ID / CERTIFICATE NO.	EMPLOYEE NAME			DATE OF BIRTH (MM/DD/YY)
ADDRESS:	TOWN	PROVINCE	POSTAL CODE	HOME PHONE #

ASSIGNMENT OF BENEFITS - (Please use Electronic Card for Drugs and Dental) Assignment available for Paramedical, Vision, Ambulance

I hereby assign any benefits payable for eligible services or medical supplies provided by the following providers and authorize direct payment to said provider(s):

_____ _____

_____ _____

Plan Member Signature: X _____

COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If "Yes", name of family member insured _____ Relationship to Employee _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's Date of Birth (MM/DD) _____ / _____

Is treatment required as the result of an accident? ☐ Yes ☐ No If "Yes", give date, location _____

and explain how the accident happened _____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

CLAIM DETAILS

Name of Person Incurring Expense	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Full-Time Student? YES	Full-Time Student? NO	Description of Expense	Date Expense Incurred (MM/DD/YYYY)	Amount Paid
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
						TOTAL OF ALL RECEIPTS ON THIS CLAIM:	

At Belmont Health & Wealth, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Belmont Health & Wealth, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Belmont Health & Wealth to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE: X _____ DATE: _____