



# Extended Health Claim Form

- Read instructions before completing this form.
- Use this form for all medical claims that are not drugs, for dental claims use the Dental Claim form, for drug claims use the Drug Claim form.
- All claims must be received by Assumption Life no later than 12 months after the date of service or purchase.
- A separate form must be filled out for each patient.
- Sign and mail your claim to the address at the bottom of the form.
- Attach original receipts showing patient's name, cost, and the date of service or purchase. Claims for paramedical services should be accompanied by a physician's order.
- **New!** Visit [www.healthplan.sfuoc.ca](http://www.healthplan.sfuoc.ca) to learn how to track your claims online and receive your reimbursements by direct deposit.

## A Information about you and your claim

Fully complete this section using block letters. Use your uOttawa student number as your certificate number. Write your full name, civic address, and phone number. Provide the required information about the person who received treatment (the patient).

Group # <b>1480</b>	Certificate #                     <b>O   T   T</b>	Employer, Union, or School Name <b>SFUO</b>
First Name	Last Name	Phone #
Home Address, Apt#	City	Province
		Postal Code
Patient's Name	Relationship to you self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/>	Patient's Birthday (dd/mm/yy)

## B Summary of Expenses - for paramedical services

Date of Service or Purchase (dd/mm/yyyy)	Nature of Illness of Injury	Type of Service	Amount Charged	Name of Physician Prescribing Service
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	
			\$	

## C Vision Care

<b>CHARGES</b>		<b>LENSES</b>	
Eye Examination: \$ _____		New Prescription <input type="checkbox"/>	
Frames: \$ _____		Repeat Prescription <input type="checkbox"/>	
Lenses: \$ _____		Safety Lenses <input type="checkbox"/>	
Other: \$ _____		Plastic Lenses <input type="checkbox"/>	
Total: \$ _____		Sunglasses <input type="checkbox"/>	
		Tint #: _____	
Signature of Optometrist or Optician _____		Date of Service _____	

## D Authorizing Signature

I authorize the release of any information or records requested in respect of this claim to the insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

\_\_\_\_\_

Policy Holder's Signature Date

## E Mailing Instructions - mail your claim with original receipts to the address below.

**Assumption Life**  
**P.O. Box 160, 770 Main Street**  
**Moncton, New Brunswick, E1C 8L1**

