


## EXTENDED HEALTH BENEFITS CLAIM FORM



**PLEASE NOTE:** SEE REVERSE SIDE FOR DETAILS ON HOW TO SUBMIT YOUR CLAIM.  
PLEASE RECORD THE TOTAL NUMBER OF RECEIPTS SUBMITTED.

CLIENT INFORMATION (Please Print)						
Policy Number	ID Number/BC Number	Provincial Health Number	Date of Birth	YYYY	MM	DD
Member Surname			First Name			
HAS YOUR ADDRESS CHANGED IN THE PAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	Street Address / Box No.					
	City or Town			Postal Code		
	Home Phone No. (        )			Work Phone No. (        )		
Date Moved	Cell Phone No. (        )		Email Address			

SPOUSAL/DEPENDENT INFORMATION							
Relationship to Member	First Name	Surname <small>(If different than member surname)</small>	Date of Birth			Provincial Health Number	DEPENDENT INFORMATION <small>For any over-age dependents (as defined in your policy), please indicate name of full-time educational facility being attended.</small> <b>Name of School</b>
			YYYY	MM	DD		
1	SPOUSE						
2	CHILD						
3	CHILD						
4	CHILD						
5	CHILD						

OTHER COVERAGE	
Are you or your dependents entitled to receive comparable benefits from any other insurance company, health benefits company, or other Saskatchewan Blue Cross Plan?	
<input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please indicate coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Drugs	
Name of insurance company or other health benefits company or, if other Blue Cross coverage, name of employer:	
Coverage type: <input type="checkbox"/> Employer Coverage <input type="checkbox"/> Private Policy	
Name of insured / policyholder:	
Date of birth (YYYY/MM/DD):	
Policy Identification Number or Blue Cross Policy, Section & Identification Number:	
Effective date:	Cancel date:

AUTHORIZATION AND CONSENT		
<p>I certify all information submitted is true and complete. I have not claimed and will not claim these expenses under any other insurance plan unless indicated above. I acknowledge my understanding of the purpose for which personal information is collected, used, and disclosed and consent to use of this information for myself and/or any covered dependent in accordance with the privacy protection practices of Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada or any other parties as required in order to administer and/or confirm the accuracy of this claim. I understand I may revoke my consent at any time. Privacy Policy information is available at <a href="http://www.sk.bluecross.ca">www.sk.bluecross.ca</a> or by calling 1.800.667.6853. A photocopy of this authorization and consent shall be as valid as the original. This consent complies with federal and provincial privacy laws.</p>		
NAME OF CLAIMANT (please print)	SIGNATURE OF CLAIMANT / MEMBER	DATE

## HOW TO CLAIM FOR EXTENDED HEALTH BENEFIT EXPENSES

*To ensure prompt handling of your claim, please follow these instructions carefully.*

This form is to be submitted for expenses incurred in your province of residence. Submit expenses incurred outside your province of residence on a separate **Application for Emergency Out-of-Province Hospital/Medical Expenses** (OOP) form. A copy of the OOP form is available on our website or by calling our offices.

For all dental services, including accidental dental claims, please use the **Standard Dental Claim Form** available from your dental office.

*If you require assistance with any part of the claiming process, please contact our offices.*

Regina 306.525.5025  
Saskatoon 306.244.1192  
Toll-free in Saskatchewan 1.800.667.6853  
[www.sk.bluecross.ca](http://www.sk.bluecross.ca)

### COMPLETING THE FORM

1. Please ensure the form is complete and you have signed the form before submitting it for payment. All four sections must be completed before your claim can be processed.
2. Complete the **Client Information** section.  
*Note: Your Policy Number and ID Number may be the same. Please refer to your Saskatchewan Blue Cross ID card.*
3. If you are claiming for your spouse and/or dependents, please complete the section titled **Spousal/Dependent Information**.
4. If you, your spouse, or any dependents are entitled to receive comparable benefits for the expense or services being claimed from any other health benefit plan (including another Blue Cross plan), please complete the section titled **Other Coverage**.
5. Include all supporting documents, as specified in your benefit booklet (e.g., physician's referral).
6. Please read, sign and date the section titled **Authorization and Consent**.

### ORIGINAL RECEIPTS REQUIRED

1. Attach original receipts for each expense claimed and **keep copies for your records**. If you have claimed these expenses under another plan, attach to this claim the original *Explanation of Benefits*

from that plan (see below for description) and copies of all receipts.

2. All original receipts must indicate the following information: first and last name of individual receiving the service, date(s) on which the service was obtained, the service(s) or product(s) purchased, the service provider's name and address and the amount charged. These receipts become part of our records and will not be returned.

*Note: All receipts/invoices must contain complete information to be eligible.*

3. Submit receipts for expenses with the completed claim form to Saskatchewan Blue Cross within the specific period of time indicated in your policy. Please refer to your benefit information for your claiming limitation.

### OTHER COVERAGE (Coordination of Benefits)

Coordination of Benefits (COB) is a standard practice among benefit carriers in Canada. COB allows people with more than one plan to maximize their coverage.

If you require assistance in coordinating your benefits, please contact our offices as below.

### MAIL YOUR CLAIM TO

<b>Saskatchewan Blue Cross</b> <b>Claims Department</b> PO Box 4030 Saskatoon SK S7K 3T2	or	<b>Saskatchewan Blue Cross</b> <b>Claims Department</b> 100-1870 Albert St Regina SK S4P 4B7
---	----	---

### EXPLANATION OF BENEFITS & CLAIMS PAYMENT

An **Explanation of Benefits** statement, indicating how the claim was assessed, will be sent to the member to be used for income tax purposes or to claim under other coverage. If you are entitled to a reimbursement, a cheque will accompany the statement. If your claim is complete with all the necessary receipts and documents, the *Explanation of Benefits* and cheque (if applicable) will be mailed approximately two weeks after we receive your claim. Please retain the statement and cheque stub for your records as no other statement will be issued.

All inquiries should be made within 30 days of receiving your reimbursement.