



Inpatriate/Expatriate Medical & Extended Health Claim Form

Please answer all questions fully – it helps us to provide better service.

All questions can be completed in ink (please print), however, the form must be signed and dated by ALL parties. Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Instructions to Insured:

1. Complete the Insured's Statement Section and the Extended Health Claim Section on Page 2.
2. Have your Physician complete the Attending Physician Statement Section if the claim is over \$500.00.
3. Return the ORIGINAL form, completed and signed, directly to AXA Assurances Inc. at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5
2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
645 – 7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8

4. Please retain copies of receipts for your files, as originals will not be returned.

Insured's Statement Section

(to be completed in full by the Claimant)

Policy Number: _____

1. Insured's Full Name _____	Date of Birth	D	M	Y
2. Dependent's Full Name (if applicable) _____	Relationship to Insured/Employee _____	Date of Birth		
_____	_____	D	M	Y
_____	_____	D	M	Y

(if space is insufficient, please use a separate sheet of paper)

3. Name and address of post-secondary school he/she is currently attending if dependent child is age 21 or older.

Please include Proof of Registration/Enrollment

4. Complete Address in Canada _____

Number & Street	City	Province	Postal Code
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5. Complete Address outside Canada _____

6. Email Address (if applicable) _____

7. If Expatriate – indicate date of departure from place of posting D M Y
 expected date of return to place of posting D M Y

8. Are you or your dependents eligible for benefits under a Provincial Health Plan? Yes No

Any other medical plan? Yes No If "Yes", please complete the following

Name of eligible family member? _____ Relationship? _____

Name of Insurance Company administering the Plan _____

Policy Number _____ Type of Coverage _____

9. Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

Bank # _____ Transit # _____ Account # _____ Please attach a "Void" cheque

Assignment

(To be completed by the employee if cheque is to be made payable to the Provider). This assignment is limited to physicians and hospitals for payment over \$500.00.

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

 Signature of Insured Employee

 D M Y
 Date

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 Telephone Number

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

