# MEDICAL EXPENSE CLAIM FORM

Send all claims and inquiries to:


COUGHLIN
employee benefits specialists

**Mailing Address:**
P.O. Box 764
Winnipeg, MB R3C 2L4

**Street Address:**
175 Hargrave Street,
Suite 100,
Winnipeg, MB R3C 3R8

**Tel.:**
**local -** (204) 942-4438
**toll free -** 1-888-204-1234

**E-mail:**
winnwebmaster@coughlin.ca

**Fax:** (204)-943-5998


## Plan Member - insured

Group or employer _____ Personal Identification No. _____

Plan Member's Full Name _____ Date of Birth y m d _____

Address _____ Language Preference ☐ English ☐ French

City _____ Province _____ Postal Code _____ Residence Telephone No. _____ Work Telephone No. _____ ext. _____

Are any health benefits or services provided under any other group insurance or health plan, workers' compensation or government plan?

☐ NO ☐ YES

If YES, who is the member of this other plan? Name _____ Date of Birth y m d _____ Relationship to Plan Member _____

Name of other insuring agency or plan _____ Policy No. _____ Certificate No. _____

## Dependants

**Please complete this section if you are claiming an expense for a dependant.**
For co-ordination of benefits, children must claim under the plan of the parent whose birthday occurs earlier in the calendar year.

| | Last Name | First Name | Date of Birth (y m d) | Complete this section, if dependant is age 21 or over. Name of School | Current or most recent registration period |
|---|---|---|---|---|---|
| Spouse | | | | | |
| Child(ren) ☐ Daughter ☐ Son ☐ Other (describe) | | | | | |
| ☐ Daughter ☐ Son ☐ Other (describe) | | | | | |
| ☐ Daughter ☐ Son ☐ Other (describe) | | | | | |

## ☐ Drug Expenses

**Attach original receipts containing the drug identification number (DIN) and name of the drug.**

## ☐ Vision Care Expenses

**Attach original itemized receipts.**

Date of final payment y m d _____

Is this a new prescription? ☐ YES ☐ NO

If NOT, reason for replacement _____

Check One
☐ Single ☐ Bifocal
☐ Contact lenses ☐ Trifocal

Check One (if applicable)
☐ Occupational safety glasses
☐ Prescription sunglasses
☐ As a result of cataract surgery (attach physician's recommendation)

Cost of lens(es) $_____
Cost of frame(s) $_____
Dispensing fee $_____
Examination fee (if applicable) $_____
Other (please explain) $_____
Total charges $_____

## ☐ Other Expenses

**Attach original itemized receipts.** For equipment and appliance expenses, Coughlin & Associates Ltd. requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

| Nature of expense | Date Incurred (y m d) | Recommended by: Physician's Name | Amount $ |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**I authorize** Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

**I certify** that the information given is true, correct and complete to the best of my knowledge.

Date y m d _____ Plan Member's Signature _____

**Protecting your personal information** The administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefit plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.