



EHC CLAIM EXTENDED HEALTH CARE BENEFITS

EMPLOYEE STATEMENT

Employer	Date of Birth (dd/mm/yy)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Group #	Certificate #
Employee Name		Employee Address (Street, Province and Postal Code)		

TOTAL EACH TYPE OF EXPENSE FOR EACH CLAIMANT ON A SEPARATE LINE

Attach a receipt for each expense listed

Claimant's First Name	Relationship	Date of Birth			Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
		Day	Mo.	Yr.			
TOTAL							

Is this claim for a work related accident or sickness on yourself or your dependent(s)? No Yes
 If 'Yes', has a claim been submitted to WCB/WSIB? No Yes

If this claim is for a dependent, is the dependent employed? No Yes - If 'Yes' Full-time Part-time
 If 'Yes', indicate name and address of dependent's employer:

Does the claimant have any other group health coverage? No Yes
 If 'Yes', indicate the name of the employer and the insurance company:

Falsifying or tampering with claim documents / receipts could have legal consequences

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.

Please do not use this form for emergency Out-of-Province/ Out-of-Canada (OOC) claims.
 All OOC claims must be submitted directly to Allianz Global Assistance, which administers & services RWAM's Travel Assist plan.
 Allianz's claim form with its address can be downloaded from RWAM's website at www.rwam.com.

Authorization:

I certify that the expenses listed above and for which the receipts are attached were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are true, full and complete.

I understand that the information provided by me to RWAM Insurance Administrators Inc. ('RWAM') in connection with this claim and any of my relevant related claims will be used for the purposes of determining my eligibility for the benefits claimed under my policy/plan, and for validating, administering and processing my claim. I authorize the release and/or exchange of any information relating to this claim to or by RWAM and to or by any other parties, as may be required in order to administer, process and confirm the validity and/or accuracy of this claim. If I am claiming for my eligible dependent spouse/child, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and exchange of their personal information for the same purposes. This authorization shall remain valid for as long as I am claiming benefits or service, or until revoked in writing by myself.

A photocopy, facsimile transmission or scanned copy of this authorization shall be considered as valid as the original.

SIGNATURE OF EMPLOYEE _____ DATE (dd/mm/yy) _____ TELEPHONE NO. _____

Send completed form to: RWAM INSURANCE ADMINISTRATORS INC.
Attention: Health Claims Department
 49 Industrial Drive, Elmira, Ontario N3B 3B1

Email: web-groupclaims@rwam.com

Fax: 519-669-1923