MEDICAL EXPENSE CLAIM FORM

Send all claims and inquiries to:

Print Form

COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd. is a People Corporation company

Mailing Address:
PO Box 764
Winnipeg MB R3C 2L4

Tel.:
(204) 942-4438
1-888-204-1234

Fax:
(204) 943-5998

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

E-mail:
winnclaims@coughlin.ca

www.coughlin.ca

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.

Complete this section, if dependant is age 21 or over.

	Last Name	First Name	Date of Birth (y m d)	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. ("Coughlin") to collect, use, maintain and disclose my personal information with the following persons, organizations or parties: health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies and their reinsurers and/or service providers; employers or former employers; my local union and auditors; and the plan administrator Coughlin for the purposes of group benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility. 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 _____ You must print THEN sign this form

Protecting your personal information The administrator of your group benefits 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 benefits 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.