

HEALTH CLAIM FORM

Expenses must be submitted within 6 months of the date incurred.

IMPORTANT: The initial Claim submitted for Massage Therapy, Physiotherapy and Psychology Services must be accompanied by a Referral Note from your Medical Doctor which clearly indicates the diagnosis. These notes are valid for a period of 2 years.

Please ensure that the drug name and drug identification number (DIN) appear on all official drug receipts. This information is available from your pharmacist. Group your receipts by family member and attach them to the back of this form. Please ensure the total is completed at the bottom. Retain photocopies for your files as original receipts will not be returned. Your benefits statement is sufficient for tax purposes and for coordination of benefits.

Employee's Full Name: _____

Home Mailing Address: _____

Employer Name: _____

Coordination of Benefits:	Are you, or any other member of your family entitled to benefits under any other plan?	Yes	No
If Yes: →	Name of Family Member Insured:	_____	
	Relationship to Employee:	_____	
	Name of Insurance Company:	_____	
	Policy Number:	_____	

Patient's Name	Birth Date (MM/DD/YY)	Relation to Employee	Service Type	Drug Name	Service Date (MM/DD/YY)	Amount
						\$
						\$
						\$
						\$
						\$
						\$
						\$

Are Any of the Patients Listed Dependents over 21 Years Old and a Full Time Student? Yes No

Name of School _____

Please Enclose Your Original Medical Receipts **Total** \$

Please mail original receipts to:



Attention: Group Benefits Department
 262 Queen Street South
 Kitchener ON N2G 1W3
 email: info@kechnie.com

Signature of Employee