KECHNIE BENEFITS

Please send completed forms to:

Kechnie Benefits
447 Frederick Street – 4th Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

EXTENDED HEALTH CLAIM FORM

Section 1 Employee Information

To be completed by member unless otherwise indicated. Receipts must be provided for all expenses. Please retain copies for your files as original receipts will not be returned.

Employee Last Name	Employee First Name	○ Male ○ Female	Date of Birth (M/D/Y)
Employee Address	Phone No.	Email	
Employer Name	Group Number	Certificate Number	

Section 2 Coordination of Benefits

Are you or any other family member entitled to benefits under any other plan? Yes ☐ No ☐

If yes → Name of family member ______________________ Relationship to employee ______________________

Name of insurance company ______________________ Policy number ______________________

Are any of the services claimed required as a result of an accident? Yes ☐ No ☐

If yes, are you seeking damages from a third party? Yes (if yes, attach details) ☐ No ☐

Section 3 Claim Details

Please ensure that the drug name and drug identification number (DIN) appear on all pharmacy receipts and attach them to the back of this form. Please be sure to make a copy of claim form and receipts for your own files if needed.

ORIGINAL RECEIPTS MUST BE ATTACHED FOR ALL EXPENSES

Patient's name	Birth date (MM/DD/YY)	Relationship to Employee	Service type	Service Date (MM/DD/YY)	Full-time Student	School	Amount
					☐Yes ☐No		$
					☐Yes ☐No		$
					☐Yes ☐No		$
					☐Yes ☐No		$
					☐Yes ☐No		$
						Total	$

Section 4 Health Care Spending Account (If Applicable)

Please indicate if you would like any remaining balance paid from your Health Care Spending Account: Yes ☐ No ☐

Section 5 Authorization and Signature

I certify that I and/or my dependents incurred these expenses and that the information given is true and complete.

______________________________ ______________________

Employee Signature **Date**

For Kechnie Office Use Only:

Date Received:____________ Date Processed: ____________ Adjudicator Initials:______

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At Kechnie Benefits we recognize and respect the importance of privacy and have always been committed to protecting your privacy and personal information. We will limit access of personal information for the purposes identified. We will not use, disclose, or retain personal information for purposes other than those for which it has been collected, except with the consent of the individual as required by law.

For Kechnie Office Use Only:

Date Received:______________ Date Processed: ______________ Adjudicator Initials:_______