

## SUPPLEMENTARY MEDICAL BENEFITS CLAIM FORM

CITY       PROV.       POSTAL CODE       CERTIFICATE/LD.NUMBER       DATE OF BIRTH         1. Please answer gll questions. This datim will be returned to you if it is incomplete or contains errors.       2. A remodula thoreful a slop provided through another of complete the member under the other plan.       Monther the following information about the person who is the member under the other plan.         Members Name	INSURED'S LAST NAM	RED'S LAST NAME					AMES		NA	NAME OF EMPLOYER					
	ADDRESS	DRESS			APT.				PC	POLICY NUMBER			[	DIVISION (IF APPLICABLE)	
2. As modula bandita bandita bandita bandita growtide through nanother Groug Insurance Plan? Yes   No   If "Yes" complete the following information about the person who is the member under the other plan. Member's Name Policy Plan # read a motion of the person of	CITY		PRO	V.			POST	AL CODE	CE	RTIFICATE/I.D	. NUMBER			DATE	OF BIRTH
Member's Name															
Insurance Company's NamePolicy Plan #															
Insurance Company's NamePolicy Plan #	Member's Name				Cert/I.D#					Date of Birth/					
It he Group Insurance Plan mentioned in this question is an Equitable Life plan and inforce, do you want us to co-ordinate benefit? Yes \_ No       No         3. Are claims being submitted as a result of an accident? Yes       No       If "Yes" give date, location and explain how accident happend.         4. Are any expenses related to an illness/injury that is work related? Yes       No       Image: Comparison of this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life hold in their files, willibu used by Equitable Life for the purposes of claims processing and adjudication. Lunderstand and authorize that for the above purposes are trained by Equitable Life for the purposes of traine processing and adjudication. Lunderstand and authorize that for the above purposes are trained by Equitable Life for the purposes of traine processing and adjudication. Lunderstand matching and the above purposes are too accessible to and may be exchanged information or the scence purpose. Inducting but not limited to accessing the claims with methors the scence and an authorizen the above purposes. Understand that claims methors the foroup insurance Policy are the purpose of confirming eligibility and assessing and managing the claim.         Including a spouse and cod quepartiest. Control the purpose of confirming eligibility and assessing and managing the claims.       Dete         Entiple Signature       Date       Date       Dete         Entiple Signature       Sign	Insurance Company's Name									Policy Plan #					
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A. Are any expenses related to an illness/njury that is work relate? Yes No      Icarlily that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equilable     Icarlily that the information given on this form is true, correct and complete to the best of my knowledge. The claim information and authorize that for the above purposes     also distribution network, participating mensurer(s), other insurance companies, investigative orgen or in any vibration also applies to     the collection, used and any other person or party wind a lauborize     autorize that of the above purposes     autorize that of the above purposes     also distribution network, participating mensurer(s), other insurance companies, investigative orgen or that with our of the same purposes. Inderstand that claims made under the Group Insurance Policy are     autorized through the as the plan member. It herefore authorize Equilable Life to exchange information about these claims with me or any person acting on my     bealt, including a spouse of dependent, is deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.  Employee's Signature     Date	If the Group Insurance	Plan n	nentio	ned in	this c	questic	on is a	n Equitab	le Life plan	and inforce, d	o you want us to co-	ordinat	e bene	efits?	Yes 🖬 No 🖬
Certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life life of the purposes of claims processing and adjudication. Lundrest and and authorize that for the above purposes the personal information of the scressibilit or and may be exchanged with, authorized employees of, and relevant thing parties relating by Equitable Life life to the purposes. Indexting a strue or provider, including, but not limited to phramacies, physicians, dentities, and any other person or party whom I authorized to act on their behalf and therefore this consent and authorization also applies to ecological and applies to each accomplication of the personal information for the same purposes. Lunderstand that claims made under the Group linearance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information above claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of consequences.         Employee's Signature       Date         Engloyee's Signature       Date         Falsifying or tampering with claim documents / receipts could have legal consequences.       Nature of the purpose of consequences.         Natch all original receipts (photocopies or carbon copies are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc.         DVICE EXPENSES       Explanation of the purpose of consequences.         Patienting       Date of Birm         Patienting       Date of Birm         Patienting       Date of Birm         Patienting       Date of	3. Are claims being sub	mitted	l as a	result	of an	accide	ent?	Yes 🗅	No 🗅	lf "Yes" giv	e date, location and	explair	ו how	accide	nt happened.
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Patient's       Date of Birth       full-time university or college student       Type of Expense       Amount Charged for Each Expense       Date of Visit or Purchase       Practitioner's or Supplier's Name         1<	OTHER EXPENSES (Excluding Drugs)										Ŧ				
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