SMART EMPLOYEE SOLUTIONS BENEFITS

HEALTH CARE EXPENSES AND VISION CARE FORM

PLEASE NOTE: Attached the receipts for all expenses and itemized them by providing all the information requested. Original receipts will not be returned as this will be part of our records.
IMPORTANT: Please ensure the form is completed and you have signed the form. All sections must be completed before your claim can be processed. All claims under this group plan are submitted through the plan member.

EMPLOYEE'S INFORMATION

Group / Policy No			Group NAME	
CERTIFICATE			EMPLOYEE NAME	
ADDRESS: NUMBER, STREET AND CITY	PROVINCE	POSTAL CODE	Home Phone#:	Work Phone#

DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth (dd/mm/yy)	Full time Student (Yes / No)	For any overage dependent (as defined in your policy) please indicate name of full-time educational facility being attended- Name of School

COORDINATION OF BENEFITS

Are you or your dependents entitled to receive benefits under any other plan?			Yes	No	If "Yes " complete the following
Name of family member insured		Relationship to employee			
Name of other insurance company		Policy number			
Is any member of your family (other than yourself) insured as an employee under this plan?			Yes		No
If "Yes" to either questions above, and the patient is a dependent child please provide spouse' date of birth				Year	Mth / Day
Is treatment required as the result of an accident?			Yes	No	If "Yes " complete the following
Give date, location and explain how accident occurred					
Is a claim being made for Workers Compensation Benefits?		Yes		No	

CLAIM DETAILS

Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of illness	Total Charge

Please attach separate sheet if additional space is required

AUTHORIZATION AND CONSENT

I certify the information submitted is true and completed. At SES Benefits we acknowledge the importance of privacy. Personal information collected will be used for the purposes of administering your group benefit plan and assessing your claim

Signature ---------- Date ----------

FOR CLAIMS OR COVERAGE INQUIRES, PLEASE CALL US AT OUR TOLL FREE NUMBER

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Toronto, Ontario M9W 5L6

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