C&C
Insurance Consultants Ltd.
6-22425 Jefferies Rd., Komoka, ON N0L 1R0

HEALTH CLAIM FORM

BENEFIT	COVERAGE MAXIMUM
Health & Dental	$800 COMBINED/12 MONTHS

Scanned claims can also be submitted by email to Info@ccinsurance.ca.
Be sure to retain original or copied receipts for your claim for 7 years.
Don't forget to include:
- For drugs, the official drug receipt (scanned, photocopied, or original);
- For dental, the standard dental claim form and proof of payment (unless asking C&C to pay the dentist directly, which will be indicated on the standard dental claim form);
- For eye exam, type of eye exam and proof of payment; or,
- For glasses, a copy of the prescription, itemized receipt for glasses, and proof of payment.

Usually you get a cash register tape or POS tape when you pay and can tape that to the dental or vision invoice, trying not to cover any pertinent information.

EMPLOYEE STATEMENT

EMPLOYER	MEMBER/EMPLOYEE NAME	SEX M F
TRENT UNIVERSITY/CUPE 3908		
EMPLOYEE'S ADDRESS (Street, Province, Postal Code)		DATE OF BIRTH D M Y

Total each type of expense for each claimant on a separate line

FULL NAME	RELATIONSHIP	DATE OF BIRTH Day ¦ Mo. ¦ Yr	TYPE OF EXPENSE i.e. dental, eye glasses, prescription drugs	DATE EXPENSES INCURRED Day ¦ Month ¦ Year	TOTAL AMOUNT CHARGED
				TOTAL	

IS THIS CLAIM ON YOURSELF OR YOUR DEPENDENT(S) FOR A WORK RELATED ACCIDENT OR SICKNESS? YES_ NO _

IF THIS CLAIM IS FOR DEPENDENT, IS THE DEPENDENT EMPLOYED: YES __ NO FULL TIME PART-TIME	IF YES, INDICATE THE NAME AND ADDRESS OF DEPENDENT'S EMPLOYER
DOES THE CLAIMANT HAVE ANY OTHER GROUP HEALTH COVERAGE? YES NO	IF YES, INDICATE THE NAME OF THE EMPLOYER AND THE INSURANCE CO.
IF THIS CLAIM IS FOR A CHILD OVER 21 YEARS OF AGE, DOES THE CHILD ATTEND SCHOOL? YES __ NO _ FULL TIME ___ PART-TIME ___	IF YES, INDICATE THE NAME AND ADDRESS OF THE SCHOOL

I certify that the charges for the medical supplies which are listed above and for which the bills are enclosed, were incurred by myself or one of my eligible family members. The charges were incurred upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness. I hereby authorize the release to C&C Insurance Consultants Ltd. of any information requested in respect of this claim. A photocopy of this authorization shall be as valid as the original.

……x……

Date Signature of Employee Telephone No.

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.