

EHC CLAIM EXTENDED HEALTH CARE BENEFITS

| EMPLOYEE STATEMENT | | | | | | | | | | | | |
|--|--|--|--|---------------------------------------|---|---|------------------------------|--|---|--------------------------------------|--|--|
| Employer | | | | | of Birth m/yy) | Male Female | | Group | # | Certificate # | | |
| Employee Name | | | | | Employee Address (Street, City, Province and Postal Code) | | | | | | | |
| TOTAL EACH TYPE OF EXPENSIFOR EACH CLAIMANT ON A SEP | | | Attaci | h a rec | eipt for eac | ch expen | ıse li: | sted | | | | |
| Claimant's First Name | Relationship | Date of Birth Day Mo. Yr. | | | Type of Expense i.e. Drugs, Vision, Practitioner, etc. | | | | Date Expense Was Incurred | | Total Amount Charged | |
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| | | | | | | | | | | TOTAL | | |
| Is this claim for a work related accident or sid If 'Yes', has a claim been submitted to WCB. | • | or your de | | i)? 🗆 1 | lo □ Yes | | | | | | | |
| If this claim is for a dependent, is the depend If 'Yes", indicate name and address of depen | | □ No I | □ Yes - If | 'Yes' 🛚 | Full-time D | Part-time | | | | | | |
| Does the claimant have any other group heal If 'Yes', indicate the name of the employer ar | Ü | l No □ `ompany: | Yes | | | | | | | | | |
| Falsifying o | r tampering wi | th claim | docume | nts / re | ceipts could | l have leg | al cor | nseaue | nces | | | |
| This form must be comp | | | | | • | • | | • | | aim. | | |
| Please do not use this form All OOC claims must be subm Allianz's claim form with its ac | nitted directly to | Allianz G | Slobal Ass | sistance | , which admir | nisters & s | ervice | es RWA | M's Travel A | ssist pla | an. | |
| Authorization: | | | | | | | | | | | | |
| I certify that the expenses listed above and for recommendation and approval of the attending form are true, full and complete. | | | | | | | | | | | | |
| I understand that the information provided by rused for the purposes of determining my eligil release and/or exchange of any information rethe validity and/or accuracy of this claim. If consent and authorization also applies to the long as I am claiming benefits or service, or un | bility for the benef ating to this claim am claiming for collection, use an | its claime to or by R my eligible d exchanç | d under m WAM and e depende ge of their | y policy/p to or by a ent spous | olan, and for va any other partic e/child, I confi | alidating, ad es, as may l irm that I a | dminist be requ m auth | ering and uired in control orized to | d processing marker to administrate act on their land | ny claim. ster, proc pehalf ar | I authorize the cess and confirm nd therefore this | |
| A photocopy, facsimile transmission or sca | nned copy of this | s authoriz | ation sha | ll be con | sidered as va | lid as the o | rigina | l. | | | | |
| X | | | | | | | | | <u>-</u> | | | |
| SIGNATURE OF EMPLOYEE | | | | DATE | (dd/mm/yy | ′) | | TE | LEPHONE NO | | | |
| Send completed form | Attention | : Health | n Claims | Depar | | | | | | | | |
| Em | nail: web-grou | pclaims | @rwam | .com | | | | | | | | |

Fax: **519-669-1923**