MACNAUGHTON & WARD
FINANCIAL SERVICES LTD.

EXTENDED HEALTH CARE

PLAN MEMBER'S FULL NAME		GROUP OR EMPLOYER
PERSONAL IDENTIFICATION NUMBER		DATE OF BIRTH (DAY/MONTH/YEAR)
GROUP #	ID#	

PLAN MEMBER'S ADDRESS	STREET	APT	LANGUAGE PREFERENCE
	CITY / PROVINCE / POSTAL CODE		ENGLISH ☐ FRENCH ☐

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

DEPENDENT'S NAME (LAST NAME, FIRST NAME)	DATE OF BIRTH			RELATIONSHIP TO PLAN MEMBER (SPOUSE/DAUGHTER/ SON/OTHER: DESCRIBE)	If this claim is for a dependent child aged 21 or over, please indicate the most recent date on which the child was registered as a full-time student.			
	DAY	MONTH	YEAR		NAME OF SCHOOL	DAY	MONTH	YEAR

EXPENSES (OTHER THAN DRUGS) - Attach original receipts and list below

NATURE OF EXPENSE	DATE INCURRED	RECOMMENDED BY (PHYSICIAN'S NAME)	AMOUNT

1. Are any health benefits or services provided under any other group insurance or health plan, worker's compensation or government plan? YES ☐ NO ☐	TOTAL CLAIM $

2a. Name of other insuring agency or plan:	Policy #	Certificate #
2b. If yes, indicate member under other plan:		SELF ☐ SPOUSE ☐
NAME	DATE OF BIRTH (DD/MM/YYYY)	

N.B. For coordination of benefits, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

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I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize Macnaughton & Ward Financial Services Ltd., healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working Macnaughton & Ward Financial Services Ltd. to exchange necessary information regarding this claim to administer my health benefit plan.

PLAN MEMBER'S SIGNATURE	DATE

All information recorded on this form is confidential.

Send all claims and inquiries to:
By mail: Macnaughton & Ward Financial Services 103 - 15225 104 Avenue, Surrey, BC V3R 6Y8
Or by fax: 604.581.9142