MACNAUGHTON & WARD
FINANCIAL SERVICES LTD.

HEALTH & DRUG CLAIM FORM

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			SPOUSE	OTHER		
	DAY	MONTH	YEAR		SON	DAUGHTER	OTHER

EXPENSES (HEALTH OR 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)	
PLAN MEMBER'S SIGNATURE	DATE	

All information recorded on this form is confidential. Send all claims and inquiries to:
Macnaughton & Ward Financial Services Ltd. 103 - 15225 104 Avenue, Surrey, BC V3R 6Y8
FAX: 604.581.9142 EMAIL: claims@for-my-future.com