Saskatchewan Retail Workers Plan

PRESCRIPTION DRUG, AMBULANCE, AND PARAMEDICAL SERVICES CLAIM FORM

TO ALL ELIGIBLE EMPLOYEES
WHO ARE *NOT* COVERED BY THEIR COMPANY GROUP INSURANCE PLAN
(PLEASE REFER TO YOUR BENEFIT PLAN BROCHURE FOR DETAILS OF YOUR BENEFIT COVERAGE.)

1. Member's Name _____ (FIRST) (LAST)
2. Member's SIN/Certificate _____ 3. Member's Date of Birth ____/____/____ (DAY/MONTH/YEAR)
4. Member's Address _____ (STREET) (CITY) (PROVINCE) (POSTAL CODE) (TELEPHONE)
5. Patient(s) Name: _____ Relationship to Insured Member: _____ Date(s) of Birth: _____ Gender: _____

Note: If dependent age 18 or over indicate: ☐ STUDENT ☐ HANDICAPPED

If a dependent claim, school information is required only for dependent children age 18 or over. _____

6. Any of these expenses related to a Worker's Compensation Claim? ☐ Yes ☐ No If yes, date of accident _____
7. Are health benefits payable from another group plan?
   ☐ Yes (Please provide name of employer and name of Group Medical Carrier) _____
   ☐ No if you previously had coverage, indicate cancellation date _____

PLEASE ATTACH ORIGINAL RECEIPTS AND COMPLETE ALL INFORMATION. INCOMPLETE FORMS AND PHOTOCOPIED/DUPLICATE RECEIPTS CANNOT BE PROCESSED FOR PAYMENT.

PRESCRIPTION DRUG, AMBULANCE, AND PARAMEDICAL SERVICES EXPENSES

TOTAL # OF RECEIPTS SUBMITTED	TOTAL $ AMOUNT SUBMITTED	RECEIPT DATE DAY/MONTH/YEAR	DESCRIPTION OF EXPENSES	CHARGE
			TOTAL	
			GRAND TOTAL	

HEALTHCARE SPENDING ACCOUNT

If applicable, any amount not eligible for reimbursement from the contents of this claim (e.g. deductible and co-insurance payment, claim that has exceeded an allowable maximum, health and dental expenses not covered under group insurance plan, etc.) is to be automatically applied to the extent of the balance in the Healthcare Spending Account, if any. ☐ YES ☐ NO

I AUTHORIZE

- my personal physician and any health care professional, public/private health or social services organization, insurer, reinsurer, employer, or other public/private organization or person that has record or knowledge of me or my health, to give any such personal information to the Plan Administrator/insurer its reinsurers, or any consumer reporting agency acting on its behalf, for assessment of claims, and benefit administration.
- the Plan Administrator of the insurer to obtain from and exchange with any of these organizations or persons any such personal information for the purposes the use of my Social Insurance Number (SIN) for claim identification purposes (Member only) and, as required by law for Income Tax Reporting.
- A copy of this authorization shall be as valid as the original.

For more information and for claim submission purposes, the Administrator is as follows:

Coughlin & Associates Ltd.
P.O. Box 764
Winnipeg, MB R3C 2L4
Toll Free: 1-800-665-0122
Fax: (204) 943-5998
E-mail: webmaster@coughlin.ca

_____ Dated _____
Member's Signature

MAIL THE COMPLETED FORM AND ORIGINAL RECEIPTS TO THE PLAN ADMINISTRATOR'S OFFICE FOR PROMPT PROCESSING

Saskatchewan Retail Workers Plan

VISION CARE COVERAGE CLAIM FORM

TO ALL ELIGIBLE EMPLOYEES
WHO ARE *NOT* COVERED BY THEIR COMPANY GROUP INSURANCE PLAN
(PLEASE REFER TO YOUR BENEFIT PLAN BROCHURE FOR DETAILS OF YOUR BENEFIT COVERAGE.)

1. Member's Name _____ (FIRST) (LAST)
2. Member's SIN/Certificate _____ 3. Member's Date of Birth ____/____/____ (DAY / MONTH / YEAR)
4. Member's Address _____ (STREET / CITY / PROVINCE / POSTAL CODE / TELEPHONE)
5. Patient(s) Name: _____ Relationship to Insured Member: _____ Date(s) of Birth: _____ Gender: _____

Note: If dependent age 18 or over indicate: ☐ STUDENT ☐ HANDICAPPED

If a dependent claim, school information is required only for dependent children age 18 or over. _____

6. Any of these expenses related to a Worker's Compensation Claim? ☐ Yes ☐ No If yes, date of accident _____
7. Are health benefits payable from another group plan?
   - ☐ Yes (Please provide name of employer and name of Group Medical Carrier) _____
   - ☐ No if you previously had coverage, indicate cancellation date _____

PLEASE ATTACH ORIGINAL RECEIPTS AND COMPLETE ALL INFORMATION. INCOMPLETE FORMS AND PHOTOCOPIED/DUPLICATE RECEIPTS CANNOT BE PROCESSED FOR PAYMENT.

VISION CARE CHARGES (ORIGINAL RECEIPT MUST BE ATTACHED)

Patient _____

Date of Service _____

Charges for: _____

Amount

___ Examination	Yes ☐		No ☐			$	_____
___ Lenses	☐	Single	☐	Bifocal	☐ Other	$	_____
Is this a change in prescription?	___ Yes		___ No				
___ Frames						$	_____
___ Contact Lenses						$	_____

HEALTHCARE SPENDING ACCOUNT

If applicable, any amount not eligible for reimbursement from the contents of this claim (e.g. deductible and co-insurance payment, claim that has exceeded an allowable maximum, health and dental expenses not covered under group insurance plan, etc.) is to be automatically applied to the extent of the balance in the Healthcare Spending Account, if any. ☐ YES ☐ NO

I AUTHORIZE

- my personal physician and any health care professional, public/private health or social services organization, insurer, reinsurer, employer, or other public/private organization or person that has record or knowledge of me or my health, to give any such personal information to the Plan Administrator/insurer its reinsurers, or any consumer reporting agency acting on its behalf, for assessment of claims, and benefit administration.
- the Plan Administrator of the insurer to obtain from and exchange with any of these organizations or persons any such personal information for the purposes the use of my Social Insurance Number (SIN) for claim identification purposes (Member only) and, as required by law for Income Tax Reporting.
- A copy of this authorization shall be as valid as the original.

For more information and **for claim submission purposes**, the Administrator is as follows:

Coughlin & Associates Ltd.
P.O. Box 764
Winnipeg, MB R3C 2L4
Toll Free: 1-800-665-0122
Fax: (204) 943-5998
E-mail: webmaster@coughlin.ca

_____ Dated _____
Member's Signature

MAIL THE COMPLETED FORM AND ORIGINAL RECEIPTS TO THE PLAN ADMINISTRATOR'S OFFICE FOR PROMPT PROCESSING