benecaid®

Flex Claim Form

Mail To:
Benecaid Health Benefit Solutions Inc.
Attn: Claims Department
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Complete section 1. Complete section 2 where applicable. Enter all claims information in section 3. Sign section 4. Mail to Benecaid at the address above. Missing information will result in claims not being adjudicated and this form along with the claims being returned to you without reimbursement. The address fields below are for identification purposes only. Reimbursement cheques and correspondence will be mailed to the address on file.
If your address has changed please notify Benecaid prior to submitting your claim.

1. EMPLOYEE INFO

Company Name:			Group Number:
Last Name:	First Name:		Client ID:
Street Address:		Unit #:	PO Box:
City:	Province:		Postal Code:

2. COORDINATION OF BENEFITS

Are you or your spouse covered by another group or supplementary health insurance plan? ☐ Yes ☐ No If "Yes" complete the following information:

Policy Holder Name	Name of Insurer	Policy Number	Coverage Type (Single, Family)

Are any claims the result of the following: A work related injury? ☐ Yes ☐ No A motor vehicle accident? ☐ Yes ☐ No If "Yes" complete the following information:

Name of Injured	Date of Accident	Is claim being made for Workers Compensation Benefits?
	DD MM YYYY	☐ Yes ☐ No

Claiming Options (Complete if you also have a Health Spending Account or Health Response with Benecaid)

☐ I want ALL attached eligible expenses paid from my Group Health and Dental plan ONLY
☐ I want ALL attached eligible expenses paid FIRST from my Group Health and Dental plan with any unpaid balance applied to my Health Spending Account
☐ I want ALL attached eligible expenses paid FIRST from my Group Health and Dental plan with any unpaid balance applied to my Health Response

3. CLAIMS INFORMATION

In order to process a claim the original receipt must be attached. If Benecaid is the second payer then a photocopied receipt along with the original Explanation of Benefits from the primary payer is required. Retain photocopies of your original receipts for your records.

Patient's Name (Individual that incurred the expense)	Patient's Date of Birth	Relationship to Employee	Type of Expense (Dental, Drugs, Vision etc…)	Date of Service	Amount $
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
	DD MM YYYY			DD MM YYYY	
				TOTAL	$ 0.00

4. AKNOLEDGEMENT

Use of Your Information: The insurance you are applying for, or have been provided with, is underwritten by an insurer (the "Insurer") and is administered by Benecaid Health Benefit Solutions Inc. ("Benecaid"). You agree that Benecaid and the Insurer may collect, use and disclose your information as described in the enclosed Privacy Agreement. You agree that you will only provide information about your spouse or your dependent children, if each of them have authorized you to do so, and if each of them have consented to the collection, use and disclosure of his or her information as described in the enclosed Privacy Agreement. **Certification:** You certify the information you have provided is true, correct and to the best of your knowledge and that the enclosed receipts represent a claim for services rendered to you and/or your eligible dependents. **Costs:** You understand that all costs of investigating and validating claims, including the costs of doctors notes and fees, are your responsibility and will not be paid or reimbursed by Benecaid or the Insurer, if any. **Communication:** You consent to Benecaid communicating with you via email. **Copies:** You agree that a photocopy or electronic copy of this section is as valid as the original.

Signature:		Date Signed: DD MM YYYY

benecaid®

Flex Claim Form Cont...

(Employee Name: _____)

5. PRIVACY AGREEMENT

In this Agreement, the words “you” and “your” mean any person who has requested from us, applied for, or is insured under any product or service offered, insured, reinsured, administered or sold by us. The words “we”, “us” and “our” mean

(1) Benecaid Health Benefit Solutions Inc. and Benecaid Insurance Solutions Inc. (collectively "Benecaid") and any affiliates of Benecaid. (2) any insurance company that insures your personal accident, sickness, life, travel, dental or other coverage provided through Benecaid; (3) any company that will in future provide coverage that replaces all or part of the insurance coverage listed in (2) or any other insurance currently provided through Benecaid; (4) any company that provides reinsurance to any company listed in (1) through (3); and (5) service providers for any company listed in (1) through (4).

The word “Information” means personal, health-related, financial and other details about you that you provide to us and we obtain from others outside our organization, including through the products and services you use.

You acknowledge, authorize and agree as follows:

COLLECTING YOUR INFORMATION

At the time you begin a relationship with us and during the course of our relationship, we may collect Information directly by us, or through our representatives, including:

- details about you and your background, including your name, address, date of birth, occupation and other identification, all of which are required under law;
- information you provide through the application and claims process for any of our insurance products or services; and
- information for the provision of insurance products and services.

This Information may be collected from you and from sources outside our organization, including from:

- government agencies and registries, law enforcement authorities and public records;
- any healthcare professional, medically-related facility, insurance company, or other person who has knowledge of; your information
- other service providers, agents, brokers and other organizations with whom you make arrangements; other insurance companies;
- your employer; references you have provided; and
- persons authorized to act on your behalf under a power of attorney or other legal authority.

You authorize those sources to give us the Information.

USING YOUR PERSONAL INFORMATION

This information may be used for the following purposes:

- to administer your insurance and your trust accounts (if any); to communicate with you;
- to verify your identity and investigate your personal background; to investigate, adjudicate, manage and coordinate your claims;
- to arrange and maintain insurance products and other services you may request; to help us better manage our business and your relationship with us;
- to evaluate and underwrite insurance risk, re-price medical expenses and negotiate payment of claims expenses;
- to better understand your insurance situation; to offer you products and services to meet your needs; to determine your eligibility for insurance and non-insurance products and services we offer;
- to detect and prevent fraud;
- to compile statistics; to help us better understand the current and future needs of our clients; and
- as required or permitted by law.

DISCLOSING YOUR INFORMATION

We may disclose your Information, including as follows:

- to other insurance companies, other financial institutions and health organizations;
- to any health-care professional, medically-related facility, insurance company or other person who has knowledge of your personal Information; to appropriate public health authorities.
- to administrators, service providers, reinsurers and prospective insurers and reinsurers of our insurance operations, as well as their administrators and service providers for these purposes;
- in response to a court order, search warrant or other demand or request, which we believe to be valid;
- to meet requests for information from regulators, including self-regulatory organizations of which we are a member or participant, to satisfy legal and regulatory requirements applicable to us;
- to our employees, suppliers, agents and other organizations that perform services for you or for us or on our behalf;
- when we buy or sell all or part of our businesses or when considering such transactions;
- to help us collect a debt or enforce an obligation owed to us by you; and
- where permitted by law.

Telephone discussions – When speaking with one of our telephone service representatives, we may monitor and/or record your telephone discussions for our mutual protection, to enhance customer service and to confirm our discussions with you.

MORE INFORMATION

Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details regarding how your privacy is protected can be obtained by asking us for a copy of our Privacy Policy.

Please read our Privacy Policy for further details about this Agreement and our privacy policies. Visit **www.benecaid.com** or contact us for a copy.

You acknowledge that we may amend this Agreement and our Privacy Policy from time to time to reflect changes in legislation or other issues that may arise. We will post the revised Agreement and Privacy Policy on our website listed above. You acknowledge, authorize and agree to be bound by such amendments.

If you wish to opt-out or withdraw your consent at any time for any of the opt-out choices described in this Agreement, you may do so by contacting us at: **1-877-797-7449**. Please read our Privacy Policy for further details about your opt-out choices.

benecaid®

Flex Claim
Submitting Instructions

How do I Submit Claims?

In order to be reimbursed for eligible medical and dental expenses the following forms and supporting documentation must be submitted to Benecaid.

Prescription Medications

- Benecaid Claim Form with original signature
- Original computerized Official Prescription Receipt with Pharmacist signature or stamp

Dental Treatments

- Benecaid Claim Form with original signature
- Original Standard Dental Claim Form, including the Dentist's signature or stamp

Optical Services

- Benecaid Claim Form with original signature
- Copy of Original Prescription for Eyeglasses or Contact Lenses
- Original receipt of payment

Other Services (i.e. Chiropractic, Chiropodist, RMT, etc.)

- Benecaid Claim Form with original signature
- Original receipt from the licensed Medical Practitioner, including all the following information:
    - Practitioner, Address and Phone Number
    - Name of the licensed Medical Practitioner who performed the service
    - License number and credentials of the Medical Practitioner
    - Patient Name
    - Date of Service
    - Amount of money paid
    - Description of service or treatment
    - Signature or stamp of the licensed Medical Practitioner who performed the service

How do I submit a claim when there are two insurers?

When submitting your claims you should send them to the primary carrier first (i.e. you send your claims to Benecaid and your spouse's claims go to their insurance carrier). If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other insurance company with the original Explanation of Benefits (EOB) and copies of the receipts. Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year, If the parents have the same date of birth then the claims will be based on alphabetical order of the parents first name.

If Benecaid is the second payer then a photocopied receipt along with the original Explanation of Benefits from the primary payer is required. If the EOB is for a Dental claim, the EOB should contain procedure codes, tooth codes, tooth surfaces and provider information, If the EOB does not contain this information please submit a photocopy of the dental claim along with the EOB.

Should I keep Copies of my Original Receipts?

Always retain photocopies of your original receipts for your records.

Where do I Mail Claims?

All claims and supporting documentation must be mailed to Benecaid at the following address:

Benecaid Health Benefit Solutions Inc.
Attn: Claims Department
185 The West Mall, Suite 800
Toronto, ON M9C 5L5