REQUEST FOR REIMBURSMENT OF MEDICAL AND PARAMEDICAL EXPENSES

GROUP INSURANCE

PLEASE ATTACH YOUR ORIGINAL RECEIPTS AND THE MEDICAL RECOMMANDATION TO THIS FORM, IF APPLICABLE.
YOU CAN ALSO SUBMIT YOUR CLAIMS ONLINE AND VIEW YOUR STATEMENTS OF BENEFITS THROUGH OUR ONLINE SERVICES AT WWW.ULMUTUAL.CA
MEMBER'S NAME, TYPE OF FEES, DATE OF PAYMENT AND THE PROFESSIONAL'S NAME, COORDINATES, ASSOCIATION AND PERMIT'S NUMBER MUST APPEAR ON YOUR RECEIPTS.
IT IS IMPORTANT TO KEEP A COPY OF YOUR RECEIPTS FOR YOUR FILES. ORIGINAL RECEIPTS WILL NOT BE RETURNED.

MEMBER INFORMATION

NAME AND SURNAME OF MEMBER			EMAIL ADDRESS		CERTIFICATE
DIRECT DEPOSIT (Specimen required) ☐ REGISTRATION ☐ CHANGE	TRANSIT (5 DIGITS)	BRANCH (3 DIGITS)	FOLIO (7 DIGITS)	NAME OF EMPLOYER	GROUP
ADDRESS OF MEMBER	CITY		PROVINCE	POSTAL CODE	PHONE NUMBER

IS THIS NEW INFORMATION? YES ☐ EFFECTIVE DATE: _____ (YYYY / MM / DD)

INFORMATION ABOUT PERSONS INSURED FOR WHICH THE CLAIM IS MADE (PLEASE ANSWER ALL QUESTIONS)

SURNAME	DATE OF BIRTH (DD / MM / YYYY)	SEX	RELATIONSHIP	ARE EXPENSES RELATED TO ROAD TRAFFIC OR WORK ACCIDENT?	COVERED BY ANOTHER GROUP INSURANCE?
		☐ F ☐ M	☐ MEMBER ☐ SPOUSE	YES ☐ NO ☐	YES ☐ NO ☐
		☐ F ☐ M	☐ SPOUSE ☐ CHILD*	YES ☐ NO ☐	YES ☐ NO ☐
		☐ F ☐ M	☐ SPOUSE ☐ CHILD*	YES ☐ NO ☐	YES ☐ NO ☐

* CHILD OF 21 YEARS OLD AND OVER MUST PROVIDE AN EVIDENCE OF FULL-TIME STUDIES TO REMAIN INSURED AS A DEPENDANT UNTIL THEIR 26TH ANNIVERSARY. AN EVIDENCE IS REQUIRED EVERY SEMESTER. COURSE SCHEDULES ISSUED LESS THAN ONE MONTH BEFORE THE BEGINNING OF A SEMESTER ARE ACCEPTED AS EVIDENCE.

COMPLETE THIS SECTION IF YOU ANSWERED YES TO ANY OF THE ABOVE

ACCIDENT EXPENSES MUST BE CLAIMED TO THE CONCERNED ORGANISM FIRST.	DATE OF THE ACCIDENT (YYYY / MM / DD)	TYPE OF ACCIDENT ☐ ROAD ☐ WORK

COORDINATION OF BENEFITS THE SPOUSE MUST SUBMIT ITS FEES TO THEIR INSURER FIRST. FEES FOR CHILDREN MUST FIRST BE SUBMITTED TO THE INSURER OF THE PARENT WHOSE DATE OF BIRTH IS THE EARLIEST IN CALENDAR YEAR. COORDINATION IS MADE UPON RECEPTION OF THE STATEMENTS OF BENEFITS OF THE OTHER INSURER OR ORGANISATION ACCOMPANIED BY COPIES OF THE RECEIPTS.	NAME OF INSURER OF THE OTHER CONTRACT AND PERIOD OF INSURANCE ☐ UL MUTUAL: _____ (CERTIFICATE) ☐ OTHER: _____ FROM: _____ TO: _____	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ COUPLE ☐ SINGLE PARENT ☐ FAMILY	BENEFITS HELD ☐ DRUGS ☐ HEALTH ☐ DENTAL CARE ☐ VISUAL CARE ☐ TRAVEL

AMOUNT SUBMITTED

MEDICAL AND PARAMEDICAL	DENTAL CARE (If applicable)	HEALTH SPENDNG ACCOUNT (HSA)	COST-PLUS
$	$	☐ APPLY TO MY HSA*	$ *Administration fees will apply

* HSA: CHECK ONLY IF FUNDS ARE AVAILABLE IN YOUR HSA OR IF FEES CAN BE CARRY FORWARD (APPLIES ONLY TO HSA WITH EXPENSE CARRY FORWARD). ELIGIBLE FEES NOT REIMBURSED BY THE BENEFITS UNDER YOUR CONTRACT WILL BE SUBMITTED TO YOUR HSA. PLEASE SUBMIT FEES TO YOUR SPOUSE'S INSURER FIRST FOR COORDINATION OF BENEFITS, IF APPLICABLE.

DECLARATION AND AUTHORIZATION

I CERTIFY THAT ALL THE INFORMATION IN THIS AND THE SUBSEQUENT REQUESTS ARE COMPLETE AND TRUE AND THAT FURNITURES AND SERVICES WERE PAID AND PROVIDED ON THE DATES, FOR THE AMOUNTS AND FOR THE INSURED INDICATED.
I AUTHORIZE UNION LIFE AND ITS REINSURERS TO GATHER, TO USE, TO CONSERVE AND TO RELEASE INFORMATION ABOUT ME AND THE OTHER INSUREDS ON MY CERTIFICATE FOR THE MANAGEMENT OF MY GROUP INSURANCE CONTRACT AND THE PROCESSING OF THIS REQUEST AND THE SUBSEQUENT.
I UNDERSTAND THAT VERIFICATIONS CAN BE MADE IN ORDER TO CONFIRM THE PROVIDED INFORMATION AND THAT IN CASE OF SUSPICION OF FRAUD OR BENEFITS ABUSE, INFORMATION ABOUT ME AND THE OTHER INSUREDS ON MY CERTIFICATE CAN BE RELEASED TO CONCERNED AUTHORITIES, TO INSURANCE BROKERS AND TO OTHER INSURANCE COMPANIES AND THAT CONSEQUENCE COULD RESULT FOLLOWING THE ESTABLISHMENT OF AN EVIDENCE.
I AM AUTHORIZED BY MY SPOUSE AND/OR DEPENDANTS CONCERNED BY THIS REQUEST TO PROVIDE AND TO RECEIVE INFORMATION ABOUT THEM. I UNDERSTAND THAT INCOME TAX COULD BE REQUIRED FROM ME FOLLOWING A REIMBURSEMENT MADE FROM MY HSA (IF APPLICABLE).

SIGNATURE OF MEMBER: X _____ DATE: X _____ (YYYY / MM / DD)

RETURN TO:

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142 HERIOT STREET, P.O. BOX 696, DRUMMONDVILLE, QUEBEC J2B 6W9
PHONE: 819-478-1315 EXT. 2074 - TOLL-FREE: 1-800-567-0988 - FAX: 819-474-1990
Claims transmitted by fax are not accepted.