CLAIM FORM
Extended Health Care

A) MEMBER INFORMATION

Policyholder:

Certificate Number:

Name (First, Last): _____

Address: _____

_____

_____

Email Address: _____

Use Direct Deposit? Yes ☐ No ☐

If you would like your reimbursement deposited directly to your bank account, please enclose a "void" cheque.

B) CLAIM INFORMATION

Number of receipts attached: _____

Total Amount claimed: $ _____

Is claim the result of a Dental Accident? Yes ☐ No ☐

If you have answered YES, please attach dates and details separately.

C) DEPENDENT INFORMATION (INCLUDING SPOUSE)

Name (First, Last)	Birth Date	Relationship	Gender	Student*	School Year

* Dependents age 21 and over are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of this school year, the upper limit of the dependent definition age for students or until coverage is terminated. Proof of full-time status may be required at any time.

D) CO-ORDINATION OF BENEFITS

With Co-ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level, single/couple//family, the spouse/dependent may have with another insurance provider.

Name of Family Member: _____ **Coverage:** _____

Name of Family Member: _____ **Coverage:** _____

I authorize Johnson Inc., Plan Administrator, to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Johnson Inc., will be kept confidential and, where necessary Johnson Inc. will be exchanging personal information. I authorize the following persons to exchange with Johnson Inc. or each other, any of my personal information in their possession; any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution. I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Some of your personal information may be stored and/or processed by one or more service providers outside of Canada. For more information about our policies and practices regarding our use of personal information and of service providers outside of Canada, please contact our Privacy Officer. A full copy of our privacy statement and the contact information of our Privacy Officer is available at www.johnson.ca.

Member Signature: _____ **Date Signed:** _____

Please mail completed claim form and receipts to:

Johnson Insurance
PO Box 4287 STN A
Toronto ON M5W 5K1

1-877-406-9007 (Toll free)
www.johnson.ca