EHC CLAIM
EXTENDED HEALTH CARE BENEFITS

EMPLOYEE STATEMENT

Employer	Date of Birth (dd/mm/yy)	Male ☐ Female ☐	Group #	Certificate #
Employee Name	**Employee Address (Street, Province and Postal Code)**			

TOTAL EACH TYPE OF EXPENSE FOR EACH CLAIMANT ON A SEPARATE LINE

Attach receipt for each expense listed
Original receipts please (photocopies or scans from originals are acceptable)

Claimant's First Name	Relationship	Date of Birth Day	Mo.	Yr.	Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
						TOTAL	

Is this claim for a work related accident or sickness on yourself or your dependent(s)? ☐ No ☐ Yes
If 'Yes', has a claim been submitted to WCB/WSIB? ☐ No ☐ Yes

If this claim is for a dependent, is the dependent employed? ☐ No ☐ Yes - If 'Yes' ☐ Full-time ☐ Part-time
If 'Yes", indicate name and address of dependent's employer:

Does the claimant have any other group health coverage? ☐ No ☐ Yes
If 'Yes', indicate the name of the employer and the insurance company:

Falsifying or tampering with claim documents / receipts could have legal consequences

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.

Please do not use this form for emergency Out-of-Province/ Out-of-Canada (OOC) claims.
All OOC claims must be submitted directly to Alliance Global Assistance, which administers & services RWAM's Travel Assist plan. Alliance's claim form with its address can be downloaded from RWAM's website at www.rwam.com.

Authorization:

I certify that the expenses listed above and for which the original receipts are attached were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are true, full and complete.

I understand that the information provided by me to RWAM Insurance Administrators Inc. ('RWAM') in connection with this claim and any of my relevant related claims will be used for the purposes of determining my eligibility for the benefits claimed under my policy/plan, and for validating, administering and processing my claim. I authorize the release and/or exchange of any information relating to this claim to or by RWAM and to or by any other parties, as may be required in order to administer, process and confirm the validity and/or accuracy of this claim. If I am claiming for my eligible dependent spouse/child, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and exchange of their personal information for the same purposes. This authorization shall remain valid for as long as I am claiming benefits or service, or until revoked in writing by myself.

A photocopy, facsimile transmission or scanned copy of this authorization shall be considered as valid as the original.

X _____ _____ - -

SIGNATURE OF EMPLOYEE **DATE** (dd/mm/yy) **TELEPHONE NO.**

Send completed form to: RWAM INSURANCE ADMINISTRATORS INC.
Attention: Health Claims Department
49 Industrial Drive, Elmira, Ontario N3B 3B1

Email: **web-groupclaims@rwam.com**

Fax: **519-669-1923**