Assumption Life
Group Insurance

Extended Health Claim Form

First Name of Employee ______ Last Name of Employee ______ Policy ______ Division ______ Certificate ______

Address ______ City ______ Province ______ Postal Code ______

E-mail ______ Telephone ______

First Name of Claimant ______ Last Name of Claimant ______

Relationship to Employee
☐ Employee ☐ Spouse ☐ Child

You must attach a detailed copy of the sales receipt that includes the patient's name, the date of service and the cost of service for all extended health claim requests. We accept receipts submitted by email, fax or mail. Please note that Assumption Life may at any time require that the original receipt be sent to our office.

Section 1 Vision Care Expenses

CHARGES

Exam ______ $ Frames ______ $
Contact Lenses ______ $ Lenses ______ $
Other ______ $ (specify: ______)
Date of service : (DD/MM/YYYY) ______

Section 2 Hearing Aid Expenses

A. CERTIFIED AUDIOLOGIST'S STATEMENT

This is to certify that I have ordered a hearing aid for the above patient, on ______ (date) (DD/MM/YYYY).
Diagnosis: ______
Type of hearing aid prescribed: ______
Has the patient ever worn a hearing aid before? ☐ Yes ☐ No

______
Signature of the certified audiologist

B. PATIENT'S STATEMENT

Date of Purchase	Type of Hearing Aid	Amount Charged	Purchased From

Section 3 Other Extended Health Claims

For all other claims, check services that apply from the following:

☐ Acupuncturist ☐ Massage Therapist ☐ Osteopath ☐ Hospital Room
☐ Chiropractor ☐ Physiotherapist ☐ Podiatrist ☐ Orthopedic Shoes/Insoles
☐ Naturopath ☐ Psychologist ☐ Dietitian ☐ Other ______

I, the undersigned, certify that the information provided within is to the best of my knowledge, complete and accurate.

______ ______
Employee's Signature Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 E-mail: group@assumption.ca

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Section 4 Coordination of Benefits (if you do not have a spouse, this section does not apply)

Does your spouse have health coverage under his/her own insurance plan? ☐ Yes ☐ No

Effective Date ____/____/_______
DD MM YYYY

If yes, is the health coverage: ☐ An individual plan ☐ A family plan

Spouse's Name _________________________ Name of Other Insurer ________________________________ Contract Number ___________

Section 5 Banking Information for Direct Deposit

Please attach a blank cheque marked ''VOID'' or provide the following banking information if no cheque is available.

____
Name of Financial Institution

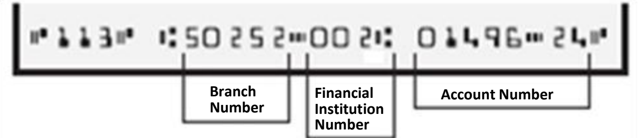
____
Branch Address

Insert the numbers found on the bottom of the cheque, as shown in the following example.

Branch Number: ☐☐☐☐☐

Financial Institute Number: ☐☐☐

Account Number: __________________________________



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