

CLAIM FORM

Submit claims to:
 Norfolk Mobility Benefits Inc.
 1100, 940-6th Avenue S.W.
 Calgary AB Canada T2P 3T1

GROUP NAME Christian Labour Association of Canada		IMPORTANT: All claims must be received by Norfolk Mobility Benefits Inc. Within 365 days after the claim was incurred, or within 90 days after the date of termination.								
NAME (First) _____ (Last) _____				POLICY NUMBER NFRW1174						
ADDRESS										
						CERTIFICATE NUMBER				
EMAIL										
Complete for all dependants being claimed for on this form										
NAME		RELATIONSHIP (Spouse, son, daughter, etc.)		DATE OF BIRTH YR MM DD		If child is aged 21 or over, please indicate if full time student and submit confirmation of enrolment.				
N/A						Student <input type="checkbox"/> Handicapped <input type="checkbox"/>				
						Student <input type="checkbox"/> Handicapped <input type="checkbox"/>				
						Student <input type="checkbox"/> Handicapped <input type="checkbox"/>				
Is treatment necessary due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, may another person be responsible? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Do you have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently making a claim with this insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, please provide name and address of insurer/contact AND policy number: _____ _____ _____						
SERVICES										
PATIENT NAME		DATE OF SERVICE YR / MM / DD	SERVICE TYPE: Doctor and/or dental visit, hospital, etc.		DIAGNOSIS/REASON FOR TREATMENT Please note diagnosis and/or reason for each service received.		AMOUNT CHARGED			
TOTAL AMOUNT CLAIMED FOR ALL SERVICES:						CURRENCY:				
PHYSICIAN'S STATEMENT - Attach original receipts. Physician statement is required if attached receipts do not include adequate information of the illness, injury and/or for treatment received. Attach additional note if necessary. _____ _____										
DOCTOR'S SIGNATURE _____				DATE _____						
DOCTOR'S NAME (PLEASE PRINT) _____										
DRUGS ONLY - PLEASE USE A SEPARATE FORM FOR ADDITIONAL ITEMS, IF APPLICABLE										
PATIENT NAME		DATE OF SERVICE YR / MM / DD	NAME OF DRUG		AMOUNT CHARGED	PATIENT NAME		DATE OF SERVICE YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED
TOTAL AMOUNT CLAIMED FOR ALL DRUGS:						CURRENCY:				
ASSIGNMENT OF BENEFITS										
If you are authorizing reimbursement to another party, please complete this section:										
NAME OF PARTY _____			SIGNATURE OF PRIMARY INSURED _____							
DATE _____										

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NAME (First) _____ (Last) _____	
CLAIM PAYMENT INFORMATION	
<input type="checkbox"/> DEPOSIT claim payment to my CANADIAN DOLLAR account via Electronic Funds Transfer (EFT).	
For Electronic Fund Payments, a void cheque <u>must</u> be attached or previously put on file. Direct Deposit is available within Canada only and accounts must be in CAD Funds.	
I UNDERSTAND IT IS MY RESPONSIBILITY TO ADVISE NORFOLK MOBILITY BENEFITS OF ANY CHANGES IN BANKING INFORMATION.	
<input type="checkbox"/> WIRE TRANSFER claim payment to my account. <i>Please note, your bank may charge you fees to receive a wire transfer. Any fees charged by the receiving bank are the responsibility of the beneficiary.</i>	
BANK INFORMATION	BENEFICIARY INFORMATION
Beneficiary Bank Name _____	Beneficiary Account Number _____
Bank Identification Number _____	Beneficiary Name _____ Last First
Address of Beneficiary Bank _____ _____	Beneficiary Address _____ _____
Currency of Bank Account _____	ABA Code (accounts in USA) _____ Swift Code (all other accounts) _____
<input type="checkbox"/> MAIL CHEQUE DIRECTLY TO MY BANK for deposit into my bank account within Canada or the USA.	
Bank Address (if applicable) _____ Account Number _____	
<input type="checkbox"/> MAIL BANK DRAFT to address provided above.	
Currency of Bank Draft (please select one): <i>Please note bank drafts are subject to the availability of currencies.</i>	
<input type="checkbox"/> AUD: Australian Dollar	<input type="checkbox"/> CAD: Canadian Dollar
<input type="checkbox"/> GBP: Great British Pounds	<input type="checkbox"/> HKD: Hong Kong Dollar
<input type="checkbox"/> MXN: Mexican Peso	<input type="checkbox"/> NZD: New Zealand Dollar
<input type="checkbox"/> SEK: Swedish Krona	<input type="checkbox"/> CHF: Swiss Franc
<input type="checkbox"/> DKK: Danish Krone	<input type="checkbox"/> EUR: Euro Dollar
<input type="checkbox"/> INR: Indian Rupee	<input type="checkbox"/> MYR: Malaysian Ringgit
<input type="checkbox"/> NOK: Norwegian Kroner	<input type="checkbox"/> SGD: Singapore Dollar
<input type="checkbox"/> USD: United States Dollar	
I hereby warrant the truth of all statements on this form and give Norfolk Mobility Benefits permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of these claims.	
SIGNATURE: _____	DATE: _____