DCM benefits.com

Group Health & Dental

Toll Free: 1-866-405-9291 ~ Ph: 902-798-8897 ~ Fax: 902-792-2411
service@dcmbenefits.com
P.O. Box 345, 42 Albert St. Windsor, NS B0N 2T0

HEALTH CLAIM FORM

Instructions

Attach a copy of the original receipts for all expenses and itemize them by providing all the information requested. Note: Drug receipts are part of our records and are not returned, therefore, retain a copy for your records. For dental claims, attach a generic dental claim form.

Important: **Please answer all questions, this claim may be returned if incomplete or contains errors.
****This form is not required when a drugstore, doctor or licensed professional direct bills your account**

Employee Information (please print)

Company Name: _____
Employee Name: _____
Address **if recently changed**: _____

Coordination of Benefits

- Are you or any other member of your family entitled to benefits under another plan? Yes_____ No_____
- If "yes", name the family member insured _____Relationship to employee_____
- Name of other Insurance Company_____Policy#_____

Patient Information: Complete for all expenses

Patient Name	Relationship to Employee	Birth Date	Full Time Student Yes or No	Name of School/ College/University	Nature of Illness	Total Charge
			Yes			
			Yes			
			Yes			
			Yes			
			Yes			
			Yes			

Total Charge = _____

I authorize release of any information or record requested in respect of this claim, to DCM benefits and certify that the information given is true, correct and complete to the best of my knowledge.
Personal information we collect from you will be used to determine your entitlement to benefits under this plan.
DCM benefits is committed to protecting clients' privacy by practicing in accordance with "PIPEDA".

You can email your claim form with receipts as attachments, to service@dcmbenefits.com, or fax your documents to **902-798-5535** (without a fax cover page)
In order to process the claim form it must be dated and signed.
Remember to keep the original claim form and supporting documents for your records and/or a possible audit.

Do not send originals already sent electronically by mail. Falsifying or tampering with claim documents/receipts could have legal consequences.
Alternatively, you can mail your completed and signed form and supporting documents to:
DCM benefits P.O. Box 345, 42 Albert St. Windsor, NS B0N 2T0

PLAN MEMBER'S SIGNATURE: _____ **DATE: Month**_____ **Day**_____ **Year**_____

DCM benefits provides services for: Life, Disability, Critical Illness, Pensions, RRSP's, RRIF's, Annuities, Investments

☐ *Check this box if you would like a call regarding any of our service*