NAME AND ID	

FORM 105

Please print clearly

CLAIMS FORM

- Use this form for all medical expenses and services.
- Attach original receipts for each expense claimed and keep photocopies for your records.
- Please print clearly and properly fill out each section to avoid delays.

Part 1 | Your Information

PLAN SPONSOR/GROUP NAME	
PLAN MEMBER NAME (Last Name, First Name)	
DATE OF BIRTH (dd/mm/yyyy)	

GROUP #		SUBSCRIBER ID#	
MAILING ADDRESS		CITY	
PROVINCE		POSTAL CODE	
HOME PHONE		WORK PHONE	
EMAIL			

Is any other member of your family insured as an employee under this plan? Yes ☐ No ☐

Please check appropriate option below to choose how you want your expenses paid.

☐ **OPTION 1** I want my eligible expenses paid from my Health Plan or Dental Plan. Do not use my Health Care Spending Account.

☐ **OPTION 2** I want my eligible expenses paid from my Health Plan or Dental Plan first and any unpaid portions of my eligible expenses paid from my Health Care Spending Account.

Note: If no OPTION box has been checked, we will pay claims according to OPTION 2.

Part 2 | Coordination of Benefits

Fill this section out if you or your spouse are covered under another plan.

Are you, your spouse or dependants covered under any other plan for the expenses being claimed? Yes ☐ No ☐

NAME OF OTHER INSURANCE COMPANY	
GROUP #	
CERTIFICATE #	
SPOUSE'S NAME (First name, Last name)	
SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)	

alberta benefits ltd.
INNOVATIVE SOLUTIONS FOR EMPLOYEE BENEFITS

#202, 10235-124th Street NW | Edmonton, Alberta, Canada | T5N 1P9
T: (780) 944-9167 | Fax: (780) 944-9168 | Toll free: 1-866-944-9167

(VER10102013)

NAME AND ID

FORM 105

Please print clearly

Part 3 | Claim Details

PATIENT NAME	# OF RECEIPTS	TYPE OF EXPENSE (ie. Pharmacy or Chiropractor)	TOTAL CHARGE

If additional space is needed attach another page.
eg. John | 6 | Pharmacy | $120
Sue | 2 | Massage | $ 80

Part 4 | Patient Information

PATIENT NAME	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (mm/dd/yyyy)	DISABLED	FULL-TIME STUDENT	IF YES, SCHOOL
			Yes☐ No☐	Yes☐ No☐	
			Yes☐ No☐	Yes☐ No☐	
			Yes☐ No☐	Yes☐ No☐	
			Yes☐ No☐	Yes☐ No☐	

I authorize release of any information or records requested in respect to this claim to Alberta Benefits Ltd, and its agents certify that the information given is true, correct and complete to the best of my knowledge. I recognize that my personal information will be collected and used to determine my entitlement to benefits under this plan.

PLAN MEMBER'S SIGNATURE	DATE (dd/mm/yyyy)

Send Completed Form to: Alberta Benefits Ltd., #202, 10235-124 Street NW, Edmonton, Alberta, T5N 1P9

#202, 10235-124th Street NW | Edmonton, Alberta, Canada | T5N 1P9
T: (780) 944-9167 | Fax: (780) 944-9168 | Toll free: 1-866-944-9167

(VER10102013)