

## SECTION A: Employee Information

Employer Name	Group No.
Employee Name	Certificate No.
Email	

## SECTION B: Coordination of Benefits

Do you want to coordinate this claim with any other coverage?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Explanation of benefits (EOB) attached:	<input type="checkbox"/>

## SECTION C: Claim Details

Patient Name	Relationship to Certificate Holder	Type of Expense	Date of Claim	Amount Claimed
			MM/DD/YYYY	\$
			MM/DD/YYYY	\$
			MM/DD/YYYY	\$
			MM/DD/YYYY	\$
			MM/DD/YYYY	\$
<b>TOTAL EXPENSES:</b>				<b>\$</b>

## SECTION D: Authorization

I authorize release of any information, or records requested, with respect to this claim(s) to Youngs-Ten Star Group Benefits Inc., and certify that the information given is true, correct and complete to the best of my knowledge. Any personal information collected will be used to determine your entitlement to benefits under this plan. All personal information will be used for the reason for which it was collected. Any other use of this information requires further consent from you.

Employee Signature:

Date: MM/DD/YYYY

## Submission

**INSTRUCTIONS:** Attach the receipts for all expenses and itemize them by providing all the information requested above. This claim will be returned to you if it is incomplete or inaccurate. **NOTE:** Receipts are part of our records and will not be returned. Therefore, please retain the Explanation of Benefits (EOB) that will accompany our cheque for income tax purposes.