Equitable Life of Canada®

EMPLOYEE REIMBURSEMENT FORM FOR PAY DIRECT DRUG CARD CLAIMS

Note: Please use this form only if you are submitting a claim for a drug expense when you were unable to use your Pay Direct Drug Card. If your Benefit Plan does not include a Pay Direct Drug Card, please use Form 466 (Supplementary Health Benefits Claim Form).

(This form is available online at www.equitable.ca or on the secure Plan Member Web Services site at www.equitablehealth.ca

Part 1 - EMPLOYEE INFORMATION - This section MUST be completed in full by the employee.

Employer Name:_____ Employee Name:_____

Employee Address:_____ _____ _____ _____

Number, street and Unit # | City or Town | Province | Postal Code

EMPLOYEE I.D. NO FROM YOUR EQUITABLE LIFE BENEFIT CARD

(Carrier) (Policy No.) (Certificate No.) (Issue No.)

Please submit completed form to:
Telus Health
Claims Department
PO Box 900 STN B
Montreal QC H3B 3K5

Is this claim an adjustment to a previously paid claim? ❑ Yes ❑ No If Yes, please have your Benefit Administrator authorize:

Part 2 - CLAIMANT INFORMATION - THIS SECTION MUST LIST ALL CLAIMANT INFORMATION.

IMPORTANT - Original pharmacy receipts MUST be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee = 01; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

Part 3 - OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of School:_____ Address of School:_____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 - CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' Compensation Board or Government Plan?
❑ Yes ❑ No If yes, please advise us of the name of the other insuring agency or plan:

Group Policy/Plan No.:_____ Cert./I.D. No.:_____

Spouse's day and month of birth:_____ Day_____ Month

If this claim has been submitted under another plan, you MUST attach the original Explanation of Benefits statement from that plan and the COPIES of the receipts.

Part 5 - OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made?_____ What is the currency of this country?_____

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, any industry drug pooling entity, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize. If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

EMPLOYEE SIGNATURE: DATE:_____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU. PLEASE KEEP A COPY FOR YOUR RECORDS. ALL INQUIRIES MUST BE MADE THROUGH YOUR EMPLOYEE BENEFIT OFFICE OR INSURANCE COMPANY.