*NO STAPLES PLEASE, PAPER CLIPS ONLY

Insurance

GENERAL CLAIM SUBMISSION FORM
(For Drug and Extended Health Claims)

SECTION 1 - PLAN MEMBER INFORMATION

PLAN MEMBER ID	EMAIL ADDRESS
SURNAME FIRST NAME	PHONE NUMBER
ADDRESS	COMPANY NAME
CITY PROVINCE	POSTAL CODE

SECTION 2 - MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? YES ☐ NO ☐

If Yes, please provide Insurance company's name _____

If other coverage is RBC Life, indicate Plan Member ID: _____

Do you want to coordinate this claim with your other RBC Life Coverage? YES ☐ NO ☐

Do you want to coordinate this claim with your Health Care Spending Account (if applicable)? YES ☐ NO ☐

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Accident (YY/MM/DD) _____

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury (YY/MM/DD) _____

If yes, WSIB / WCB Case # _____

SECTION 3 - CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY	PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM YR	MO	DAY	TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM
									TOTAL CLAIMED	

FOR PRESCRIPTION DRUG CLAIMS ONLY:

TO FACILITATE CLAIMS PROCESSING:

- **Please note: Cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required.**
- **Original receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN)**
- **If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.**

If claim is from OUT OF COUNTRY, please provide:

Name of Country Visited _____ **Currency Used** _____ **Name of Drug** _____

SECTION 4 - AUTHORIZATION

_____ _____

SIGNATURE OF PLAN MEMBER DATE

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to RBC Life about myself and my dependents, will be used by RBC Life for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize RBC Life to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

SECTION 5 - MAILING INSTRUCTIONS (See reverse for claim submission instructions)

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned. Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	OTHER CLAIMS
P.O. BOX 1613	P.O. BOX 1610	P.O. BOX 1603	P.O. BOX 1602	P.O. BOX 1601
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 0B8	N9A 0B7	N9A 0B6	N9A 0B5	N9A 0B4

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.

CUSTOMER SERVICE CENTRE 1-855-264-2174 **www.rbcinsurance.com/planmember**

The listing below may include benefits not covered by your plan.

RBC Life CLAIM SUBMISSION INSTRUCTIONS

Please call our Customer Service Centre at 1-855-264-2174 if you require any assistance in completing this form.
Please ensure that you always provide your Plan Member ID in full, including suffix (ie. 00, 01, etc.)

FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM:
Audio (Hearing Aids)	Itemized receipts showing • patient name • services & dates • audiologist name & address • breakdown of charges (i.e. Acquisition cost, fee, mold)
Prescription Drugs	All itemized prescription drug receipts from your pharmacist. Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy.
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing • patient name • individual date & nature of treatment • charge for each service Some professional services may require a medical referral/physician prescription.
Durable Medical Equipment (including prosthetics)	Itemized receipts showing • patient name • a detailed description of the equipment • name & address of supplier • date & charge for each service Some medical equipment may require a medical referral/physician prescription and/or prior authorization.
Custom Foot Orthotics	Itemized receipts showing • patient name • name and address of supplier • charge for service • casting technique • date orthotics were received A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified by your plan sponsor.
Hospital Accommodation	Itemized receipts showing • patient name • number of days in semi-private/private accommodation • rate charged per day • admission & discharge dates
Vision Care	Itemized receipts showing • patient name • copy of vision prescription • a breakdown of charges for lenses & frames • date eyewear received or paid in full
Extended Health - General	Itemized receipts showing • patient name • a detailed description of services or supplies • provider's name & address • date & charge for each service Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.
Out of Province/Country	Call Customer Service at 1-855-264-2174 for detailed claims submission instructions.
Private Duty Nursing	Call Customer Service at 1-855-264-2174 for detailed claims submission instructions. Pre-approval is required for all nursing claims - call Customer Service for details.
Medical Cannabis	Receipt/Shipping confirmation showing: • patient name • date of order • breakdown of charges (i.e. ingredient cost, taxes, shipping charges, discounts applied) • name of prescriber • authorized grams per day • medical document expiry date