Assumption Life

P.O. Box 160/770 Main Street, Moncton, N.B. Canada E1C 8L1
Tel.: 506 853-6040 Fax.: 506 853-5434

Extended Health Claim Form

EMPLOYEE'S STATEMENT

Employee's Name	Employee Number	Account Number
Patient's Name	Relationship to Employee ☐ SELF ☐ SPOUSE ☐ CHILD	Patient's Birthdate

Employee's Address Tel.:

A SEPARATE FORM MUST BE COMPLETED FOR EACH PATIENT

Part I Vision Care • Part II Hearing Aid Expenses • Part III Other Expenses (reverse side)

Part I VISION CARE EXPENSES

To be completed by an optometrist or optician when claiming for an eye examination or eye glasses

CHARGES

Eye Examination ____________

Frames ____________

Lenses ____________

Other ____________

Total ____________

LENSES

New Prescription ☐

Repeat Prescription ☐

Safety Lenses ☐

Plastic Lenses ☐

Sunglasses ☐

Tint Number ____________

____________ Date of Service

____________ Signature of Optometrist or Optician

Part II HEARING AID EXPENSES

Section (A) to be completed by Physician; Section (B) to be completed by Employee

(A) PHYSICIAN'S STATEMENT

(To be completed by a physician, who has been certified as an audiologist)

This is to certify that I have ordered a hearing aid for the above patient on ____________ Date

Diagnosis ____________

Type of Hearing Aid prescribed ____________

Did the Patient ever wear a Hearing Aid previously? ☐ YES ☐ NO

____________ Physician's Signature

(B) EMPLOYEE'S STATEMENT

(To be completed by the employee. A bill or receipt, giving the date of purchase, patient's name, and amount, must accompany your claim).

Date of Purchase	Type of Hearing Aid	Amount Charged	Purchased From

N.B.: This is a standard form. The benefits named do not apply to all employees

3587-00A-98R

PART III SUMMARY OF EXPENSES

AMBULANCE SERVICE - NURSING SERVICES - HOSPITAL OUTPATIENT - PARAMEDICAL SERVICES, etc.

AN ORIGINAL RECEIPT FOR EACH ITEM CLAIMED, GIVING THE DATE OF SERVICE AND PATIENT'S NAME MUST ACCOMPANY YOUR CLAIM. CLAIMS FOR NURSING SERVICES OR APPLIANCES SHOULD BE ACCOMPANIED BY A PHYSICIAN'S WRITTEN ORDER. PHOTOCOPIES AND FAXES ARE NOT ACCEPTABLE.

Date Service Rendered or Date of Purchase	Nature of Illness or Injury	Type of Service (Ambulance Service - Nursing - Services - Hospital Outpatient - Paramedical Services, etc.	Amount Charged	Name of Physician Prescribing Service