HEALTH CARE EXPENSES CLAIM FORM

Architype Benefits

INSTRUCTIONS: Attach the bills and original receipts for all expenses and itemize them by providing all the information requested. Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax Purposes.

IMPORTANT: Please answer all questions. This claim may be returned to you if it is incomplete or contains errors

Please Print

EMPLOYEE'S STATEMENT

PLAN NUMBER	DIVISION NO.	PLAN (Company) NAME	
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME	
ADDRESS: NUMBER AND STREET TOWN PROVINCE POSTAL CODE			PHONE NUMBER HOME: WORK:

***Is this a new address Yes / No please circle**

DEPENDENT INFORMATION ***If child is over 18 years***

Patient Name	Relationship To Employee	Birthdate Yr	Mo	Day	*Full Time Student* *Min. 60% course load*	*Name of School/College/University*
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	
					Yes ___ No ___	

CLAIM DETAILS

	DRUG EXPENSES		**OTHER EXPENSES**		
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge

COORDINATION OF BENEFITS

Are you or any other family member entitled to benefits under any other plan?	Yes	No
If yes please provide name of insured		
If yes please provide relationship to you		
Name of other insurance company		
Other insurance company policy #		
If your 'other family member' insured elsewhere is a dependant child, please provide spouse's date of birth		
Is any member of your family (other than yourself) insured as an employee under this plan?	Yes	No
If YES to either of the Yes / No questions above and the patient is a dependent child, please provide your spouse's Date of Birth		

Additional Notes / Comments:

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

I authorize release of any information or record requested in respect of this claim to ***Architype Financial / Architype Benefits,*** and certify that the information given is true, correct and complete to the best of my knowledge. I understand that personal information collected will be used to determine my entitlement to benefits under this plan. This information will remain the property of Architype Financial / Architype Benefits, and will not be provided to any other party for any other purpose save for the needs or requirements of our adjudication or CRA (Revenue Canada Taxation).

SIGNATURE OF EMPLOYEE **X**_____ DATE _____

Send To:

Architype Financial – Architype Benefits
#206-1220 Falcon Drive, Coquitlam, BC V3E 2E5 Phone (604) 942-2299 Fax (604) 944-6490