

## HEALTHCARE EXPENSES STATEMENT

**INSTRUCTIONS:** Attach the bills and original receipts for all expenses, and itemize them by providing all of the information requested below. Please answer all questions fully, as this claim will be returned to you if it is incomplete or contains errors.

**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.

### PART ONE - EMPLOYEE STATEMENT

Name of Employer	Division (if applicable)		
Name of Employee	Certificate Number		
Address	City	Province	Postal Code

### PART TWO - COORDINATION OF BENEFITS

Are you, or any other member of your family, entitled to benefits under any other plan?      YES       NO

If YES, please provide the following information:

Name of Relative	Relationship to Employee
Name of Insurance Company	Policy Number

Is any member of your family (other than yourself) insured as an employee under this plan?      YES       NO

If you answered YES to either question above, please provide your spouse's date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month

### PART THREE - DEPENDENT INFORMATION

Patient Name	Relationship To Employee	Date of Birth			If child is 19 years of age or older,	
		Year	Month	Day	Full Time Student?	Name of School, College or University
					YES <input type="checkbox"/> NO <input type="checkbox"/>	
					YES <input type="checkbox"/> NO <input type="checkbox"/>	
					YES <input type="checkbox"/> NO <input type="checkbox"/>	
					YES <input type="checkbox"/> NO <input type="checkbox"/>	

### PART FOUR - CLAIM DETAILS

*Please attach separate sheet if you need additional space.*

Patient Name	Drug Expenses		Other Expenses (i.e. Vision, Paramedical, Hospital)		
	Total Receipts	Total Expenses	Type of Expense	Nature of Illness	Total Expenses

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

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**TEN STAR Group Benefit Specialists Inc.™**

Submit claims to: Ten Star Group Benefit Specialists Inc.  
 95 Hamilton Street North, Suite 2, P.O. Box 1490  
 Waterdown, Ontario L0R 2H0  
 Phone: (905) 689-7911 or toll-free (877) 836-7827  
 Fax: (905) 689-1885 or toll-free (866) 269-5510