

MEDICAL CLAIM

INSTRUCTIONS FOR COMPLETION (PLEASE PRINT)						
1. Complete appropriate sections in full. Please print. 2. Sort all bills by family member's name and list, in date order, for each family member on the same claim for. Use a separate form for additional items, if applicable. 3. Submit original receipts. Photocopies will NOT be accepted. 4. If you require copies of your receipts, please make photocopies before you submit your claim. 5. All medical information received under this policy is confidential. As part of audits or administrative reports, your employer may have access to statistical and financial information, but your name will not appear on any medical information released to your employer.				Send fully completed claim to: NORFOLK GROUP INSURANCE TRUST #510, 940 6 Avenue SW Calgary, Alberta, CANADA T2P 3T1 IMPORTANT: All claims must be received by Norfolk Group Insurance Trust of Canada within 180 days of the end of the calendar year in which they were incurred, or within 90 days of the termination of Benefits.		
Note: Your receipts will not be returned to you.						
CONTRACT PROFESSIONAL'S NAME (First) _____ (Last) _____			POLICY NUMBER AM003842			
OVERSEAS ADDRESS			S.I.N.			
			CERTIFICATE NUMBER			
LIST OF DEPENDENTS						
NAME		RELATIONSHIP (SELF, SPOUSE, SON, DAUGHTER, ETC.)		DATE OF BIRTH		
				IF CHILD IS AGE 21 OR OVER, PLEASE INDICATE IF FULL TIME STUDENT, PLEASE SUBMIT CONFIRMATION OF ENROLMENT EACH NEW ITEM		
				YR MM DD		
				STUDENT <input type="checkbox"/> HANDICAPPED <input type="checkbox"/>		
				STUDENT <input type="checkbox"/> HANDICAPPED <input type="checkbox"/>		
MEDICAL SERVICES						
PATIENT'S NAME		DATE SERVICES RENDERED YR / MM / DD	TYPE OF SERVICE E.G.: HOSPITAL, DOCTOR'S VISIT, ETC.	AMOUNT CHARGED	PATIENT'S NAME	
					TOTAL AMOUNT CLAIMED FOR MEDICAL SERVICES	
					\$	
PHYSICIAN'S STATEMENT - ATTACH ORIGINAL RECEIPTS AND SIGN BY DOCTOR						
DESCRIBE ILLNESS, INJURY AND TREATMENT RECEIVED. ATTACH ADDITIONAL NOTE IF NECESSARY						
_____ _____ _____						
DOCTOR'S SIGNATURE _____				DATE _____		
DOCTOR'S NAME _____						
(PLEASE PRINT)						
DRUGS ONLY - PLEASE USE A SEPARATE FORM FOR ADDITIONAL ITEMS, IF APPLICABLE						
PATIENT'S NAME		DATE SERVICES RENDERED YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED	PATIENT'S NAME	
					TOTAL AMOUNT CLAIMED FOR ALL SERVICES	
					\$	
Fraudulent claims are very costly for employers and for all participants in benefits plans. As administrator of this plan, we may check the accuracy of the information given in support of your claim. I certify that the above statements are true and complete. I authorize the following to exchange information needed for underwriting, administration or paying claims: The Norfolk Group; any person or organization who has relevant personal information about me including medical practitioners, institutions and insurers; and persons performing services for Lloyd's of London.						
(PLEASE PRINT)						
<input type="checkbox"/> I WISH CLAIM PAYMENT TO BE MAILED TO THE ABOVE ADDRESS			BANK NAME: _____			
<input type="checkbox"/> I WISH CLAIM PAYMENT TO BE DEPOSITED TO MY CANADIAN BANK ACCOUNT			ADDRESS: _____			
BANK ACCOUNT NUMBER _____			POSTAL CODE _____			
CONTRACT PROFESSIONAL'S SIGNATURE _____				DATE _____		
FOR ADMINISTRATION USE ONLY - PLEASE DO NOT WRITE IN THIS SPACE						
EFFECTIVE DATE OF COVERAGE: _____			EXPIRY DATE: _____			
SIGNATURE OF AUTHORIZED OFFICIAL: _____			DATE: _____			