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C&C Insurance Consultants

Fax: 519-657-4520
 Phone: 1-888-918-5056

CLAIMS TRANSMITTAL FORM

Name of Employee: _____
 Date of Birth Male _____ Ph #: (____) _____ - _____
 YY | MM | DD Female _____ email: _____

Address: _____

 Employer: _____

MAIL CLAIMS TO:

**C & C Insurance Consultants
 6 - 22425 Jefferies Road, R.R. #5
 Komoka, ON, N0L 1R0**

ORIGINAL RECEIPTS MUST BE INCLUDED
 Photocopies and/or carbon copies are not acceptable

Name of Claimant	Date of Birth YY/MM/DD	Relationship to Insured	Type of Expenses (Drug, Vision, Hosp, Amb., Paramedical)	Date of Claim YY/MM/DD	Amount
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____
_____	__/__/__	_____	_____	__/__/__	\$ _____

Falsifying or tampering with claim documents / receipts could have legal consequences **TOTAL** \$ _____

Is this claim for a work related accident or sickness on yourself or your dependent(s)? Yes ___ No ___	
If "Yes", has a claim been submitted to WCB/W/SIB? Yes ___ No ___	
If this claim is for a dependent, is the dependent employed? Yes ___ No ___	If "Yes", indicate name and address of dependent's employer
If "Yes" Full time ___ Part time ___	
Does the claimant have any other group health coverage? Yes ___ No ___	If "Yes", indicate employer's name and insurance company
Dental ___ and/or EHC ___	

Authorization: I certify that the expenses listed above and for which the original receipts are attached were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true.

I understand the information I provide on this form to TERRA NOVA in connection with this claim and any of my relevant related claims will be used for the purposes of validating my claim, determining my eligibility for group insurance benefits claimed under my plan, administering my claim and processing my claim according to the results of the adjudication. I hereby authorize the release to TERRA NOVA of any information requested by TERRA NOVA for these purposes. I also understand and authorize that, for the purposes stated, the information gathered by TERRA NOVA may be accessible to and/or exchanged with the insurer/provider, any participating reinsurer(s), any hospital, any health care provider [i.e. including but not limited to physiotherapists, chiropractors, pharmacists, registered massage therapists, physicians, dentist], any other parties named on receipts submitted to TERRA NOVA in connection with my claim, investigative organizations, and any relevant third parties retained by TERRA NOVA. If I am claiming for my eligible spouse/child, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and exchange of their personal information for the purposes. This authorization shall remain valid for as long as I am claiming benefits or service, or revoke in writing myself.

DATE yy / mm / dd EMPLOYEE SIGNATURE TELEPHONE

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.
 10/31/2011