



# GENERAL CLAIM SUBMISSION FORM

each person must complete own claim form



Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?  
Go to [www.securiancanada.ca](http://www.securiancanada.ca) for more details

SECTION 1 - PLAN MEMBER INFORMATION			
PLAN MEMBER ID = Your plan prefix + Member ID number + 2-digit dependent code (e.g., ABC1234567-00)		EMAIL ADDRESS	
LAST NAME	FIRST NAME	PHONE NUMBER	
ADDRESS		YOUR PLAN SPONSOR / ASSOCIATION	
CITY	PROVINCE	POSTAL CODE	
SECTION 2 - MANDATORY DECLARATION			
Do you have any other group insurance coverage that may include these services as benefits?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
If we are your secondary carrier, please attach copies of your receipt and your Explanation of Benefit statement from your primary carrier. If other coverage is with Securian Canada, indicate other Securian Canada Plan Member ID: _____			
Do you want to coordinate this claim with your other Securian Canada Coverage ?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Is treatment due to a motor vehicle accident?		YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, include date of accident _____	
Include which expenses are MVA related _____			
Is treatment required due to a work related injury?		YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, include date of injury _____ WCB Case # _____	
Include which expenses are a result of the work related incident _____			
Do you want to coordinate these claims with your Health Care Spending Account (HCSA) (if applicable)?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
If yes, include which claims are to be coordinated with HCSA _____			
CLAIMANT'S NAME	DEPENDENT NO. {your plan member ID-Dependent number (e.g., ABC1234567-01); where 00 is member, 01 is for member's spouse, and 02-20 is for dependent children}.	YR	DATE OF BIRTH MO DAY
SECTION 3 - AUTHORIZATION AND CONSENT			
<p>At Securian Canada (“we,” “us” or “our”), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, “you” or “your”), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of Securian Canada, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer’s group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); Securian Canada’s third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. We implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at <a href="http://www.securiancanada.ca">www.securiancanada.ca</a>, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on <a href="http://www.securiancanada.ca">www.securiancanada.ca</a>. You can contact our Privacy Officer by writing to Securian Canada’s Privacy Office at 25 Sheppard Avenue West, Unit 1400, Toronto, ON, M2N 6S6, or call 1-888-968-4155 if you have a question or complaint.</p>			

### SECTION 3 - AUTHORIZATION AND CONSENT (CONTINUED)

By signing below, you are providing your consent to Securian Canada's collection, use and disclosure of your personal information including any information from any physician, medical practitioner, hospital, clinic, other medical related facility, insurance or reinsuring company, employer or plan sponsor, agents or service providers of the plan sponsor or consumer reporting agency having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, and/or treatment of me and any law enforcement agency having information available on me as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to Securian Canada's Privacy Office at 25 Sheppard Avenue West, Unit 1400, Toronto, ON, M2N 6S6. You understand that you may request to receive a copy of this authorization. You agree that a photocopy of this authorization is as valid as the original.

\_\_\_\_\_

Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

### SECTION 4 - MAILING INSTRUCTIONS

**PLEASE ATTACH ALL ORIGINAL DOCUMENTATION** and retain copies for your files as original receipts will not be returned.

Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

<b>PROFESSIONAL SERVICES</b> P.O. BOX 1699 WINDSOR, ON N9A 7G6	<b>MEDICAL ITEMS</b> P.O. BOX 1623 WINDSOR, ON N9A 7B3	<b>VISION &amp; ACCOMMODATION</b> P.O. BOX 1615 WINDSOR, ON N9A 7J3	<b>DRUG</b> P.O. BOX 1652 WINDSOR, ON N9A 7G5	<b>DENTAL</b> P.O. BOX 1608 WINDSOR, ON N9A 7G1
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To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above.

### SECURIAN CANADA CLAIM SUBMISSION INSTRUCTIONS

Please call our Customer Service Centre at 1-866-969-5949 if you require any assistance in completing this form.  
Please ensure that you always provide your Securian Canada Plan Member ID in full, including suffix (e.g. ABC1234567-00).

FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM: The listing below may include benefits not covered by your plan
Audio (Hearing Aids)	Itemized receipts showing claimant name, services & dates, audiologist name & address, prescriber / dispenser information and audiogram.
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing patient name, individual date & nature of treatment, and the charge for each service. Some professional services may require a medical referral/physician prescription.
Durable Medical Equipment (including prosthetics)	Itemized receipts showing patient name, a detailed description of the equipment, name & address of supplier, and date & charge for each service. <b>Some medical equipment may require a medical referral/physician prescription and/or prior authorization.</b>
Custom Foot Orthotics	Itemized receipts showing patient name, name & address of supplier, charge for service, casting technique, and date orthotics were received. A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified in your insurance documents.
Hospital Accommodation	Itemized receipts showing patient name, number of days in semi-private / private accommodation, rate charged per day, and admission & discharge dates
Vision Care	Itemized receipts showing patient name, copy of vision prescription, a breakdown of charges for lenses & frames, and date eyewear received or paid in full.
Extended Health - General	Itemized receipts showing patient name, a detailed description of services or supplies, provider's name & address, and date & charge for each service. <b>Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.</b>
Out of Province / Country	Call Customer Service at 1-866-969-5949 for detailed claims submission instructions.
Private Duty Nursing	Call Customer Service at 1-866-969-5949 for detailed claims submission instructions. Pre-approval is required for all nursing claims - call Customer Service for details.
Medical Cannabis	Receipt/Shipping confirmation showing patient name, date of order, breakdown of charges (ie ingredient cost, taxes, shipping charges, discounts applied), name of prescriber, authorized grams per day, and medical document expiry date.
Prescription Drugs	Itemized prescription drug receipts from your pharmacist. <b>Receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN).</b> Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy. If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.  If claim is from <b>OUT OF COUNTRY</b> , please also provide: <b>Name of Country Visited</b> _____ <b>Currency Used</b> _____ <b>Name of Drug</b> _____