1900, 10104 - 103 Ave NW
Edmonton, AB T5J 0H8

DENTAL & VISION CLAIM FORM

NOTE: Attach **original** receipts (photocopies, faxes and emails are not acceptable). For non-drug claims, please include explanatory letter, doctor's prescription, etc. If additional space is needed, attach a second form.

Certificate Number/Client ID	Employee Last Name	Employee First Name	Date of Birth (M/D/Y)
Mailing Address	Town	Province	Postal Code

Employer Name	Policy/Group Number	Daytime Phone Number

Co-ordination of Benefits		
1. Are you or any other family member entitled to benefits under any other plan?	❑ Yes	❑ No
-If "Yes", provide name of family member insured:		
-Relationship to employee:		
-Name of other insurance company: Policy Number:		
2. Is any member of your family (other than yourself) insured as an employee under this plan?	❑ Yes	❑ No
-If you have answered "Yes" to question 1 or 2, please provide your spouse's date of birth: (MM/DD/YYYY)		
3. Would you like any unpaid balance to be reimbursed from your Health Spending Account?	❑ Yes	❑ No

Name of Patient	Relationship to Employee	Date of Birth (M/D/Y)	Vision Receipts	Dental Receipts
		Subtotal:		

Total Claim Amount: $ _____

I authorize the release of any information or records requested in respect of this claim to the insurer / plan administrator and certify that the information given is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Strive Insure held in their file will be used by Strive Insure for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to and may be exchanged with authorized employees of the relevant and third parties retained by its sales distribution network, participating re-insurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize. If applying for my spouse and/or dependants, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the group policy are submitted through me as the plan member. I therefore authorize Strive Insure to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependant, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

Employee Signature	Date (MM/DD/YYYY)

Phone: (780) 448-1637 Toll Free: 1-866-444-1637
www.striveinsure.ca