Print Form

Alberta Benefits Ltd.
GROUP BENEFITS EXPENSES STATEMENT

ATTACH ORIGINAL RECEIPTS FOR ALL EXPENSES AND ITEMIZE THEM BELOW. BILLS, AND RECEIPTS WILL NOT BE RETURNED TO YOU. THEREFORE, PLEASE RETAIN A COPY OF ITEMIZED EXPENSES FOR INCOME TAX PURPOSES.
This claim will be returned to you if it is incomplete or contains errors.

Please Print Clearly

PART 1: EMPLOYEE'S STATEMENT			
COMPANY NAME			
EMPLOYEE NAME			
ADDRESS	**CITY**	**PROVINCE**	**POSTAL CODE**
HOME PHONE	**WORK PHONE**		

DEPENDENT INFORMATION		If child over 18 years		
Patient Name	**Relationship to Employee**	**Birthdate (Month/Date/Year)**	**Student Y/N**	**Name of University**
		/ /		
		/ /		
		/ /		
		/ /		

Coordination of Benefits

Are you or any other member of your family entitled to benefits under any other plan? Yes ☐ No ☐

If yes, Name of Other Insurance Company: _____

Policy Number: _____

Spouse's date of birth: (M/D/Y) _____

Is any other member of your family insured as an employee under this plan? Yes ☐ No ☐

CLAIM DETAILS			
Patient Name	Number of Receipts	Explanation of Expense	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

I authorize release of any information or records requested in respect to this claim to Alberta Benefits Ltd, and certify that the information given is true, correct and complete to the best of my knowledge. Personal information we collect from you will be used to determine you entitlement to benefits under this plan.

SIGNATURE OF EMPLOYEE _____ DATE _____

PLEASE SEND COMPLETED CLAIM TO:
Alberta Benefits Ltd.
#607, 10240-124 St
Edmonton, AB, T5N 3W6