beneva by La Capitale

Claim

for prescription drug and for medical and paramedical expenses

Beneva
625 Jacques-Parizeau St
PO Box 1500, Quebec QC G1K 8X9

Need some help in completing this form?
Call us at 418-644-4200 or 1-800-463-4856.
You can file claims in your Client Centre. Log in at **beneva.ca**.

1. Identification of participant

As indicated on your insurance certificate

Group No. 0 1 0 0 8

Identification No.

or

Policy No. —

Last name	First name

Check all the appropriate boxes

This claim concerns the: ☐ Participant ☐ Spouse ☐ Child(ren)

Complete this section only if your contact information has changed

New address only		
No., Street		Apartment
City	Province	Postal code
Telephone (home)	Telephone (work)	Telephone (cell)

Important

- Please enclose your **original receipts** with this form and send the documents to the address indicated at the top of this form.
- Please keep a copy of your receipts, as the originals **will not be returned**.
- You must submit your claim for benefits **within 12 months following the date** on which the expenses were incurred and the services were rendered.
- To speed up processing of your claims, please provide us with **the information requested**.

Are the expenses claimed on this form the result of:

- a **work-related injury**? ☐ Yes ☐ No
- an **automobile accident** (as defined by the SAAQ)? ☐ Yes ☐ No

If so, you must **first** submit your claim to the **CSST** or the **SAAQ**.

Name of the accident victim

Date of the accident (YYYY/MM/DD)

Continued on reverse

2. Information about the dependents – Complete this section if you are submitting a claim for a dependent.

Spouse

Last name _____ First name _____

Date of birth (YYYY/MM/DD) _____

Dependent children Last name, first name	Date of birth (YYYY/MM/DD)	Full-time student	Complete this section if you are submitting a claim for a child over age 17 or 20, depending on your group insurance contract	
			Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD)
		☐		
		☐		
		☐		
		☐		

La Capitale Civil Service Insurer Inc. reserves the right to ask you for written proof from the institution attended at any time

3. Claimed expenses

Refer to your booklet for details of eligible expenses. Attach your original receipts.

	Prescription drug expenses	Other expenses	TOTAL
Total amount of your receipts	$	$	$

4. Coordination of benefits – Complete this section if the expenses incurred are covered under another insurer's plan.

How to make a claim when there are two insurers:

a) Your spouse first submits his or her claim to his or her insurance company; then, your spouse submits details of the benefits paid and photocopies of the receipts to La Capitale Civil Service Insurer Inc.

b) Claims for dependent children are submitted to the insurance company of the parent whose birthday falls first in the year.

Type of coverage: ☐ Individual ☐ Couple ☐ Single parent ☐ Family

Name of insurer _____ Insurance start date (YYYY/MM/DD) _____

5. Health spending account – Complete this section if this coverage is indicated on your service card.

Do you want any unpaid portion of your claimed expenses to be considered under your Health Spending Account? ☐ Yes ☐ No

6. Direct deposit – Complete this section if you wish to register for or modify your account.

La Capitale Civil Service Insurer Inc. prefers to reimburse expenses by direct deposit. It is a **fast**, **easy** and **secure** way to receive your benefits **directly**. To register for or modify your account, **please enclose a cheque specimen marked "Void" or any other acceptable document.**

☐ **I hereby authorize La Capitale Civil Service Insurer Inc. to deposit my healthcare benefits into my bank account indicated on the enclosed document.**

☐ **Direct deposit account change, if already enrolled.**

X _____ _____

Participant's signature Date (YYYY/MM/DD)

7. Participant's declaration

☐ I declare that all the information provided in this claim is true and complete. I authorize any person associated with this claim to disclose any relevant information to La Capitale Civil Service Insurer Inc.

X _____ _____

Participant's signature Date (YYYY/MM/DD)