

IMPORTANT: All claims must be received by Norfolk Mobility Benefits Inc. within 365 days after the claim was incurred, or within 90 days after the date of termination.

NAME (First)	(Last)	POLICY NUMBER RG4335FRW Group #31511
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ADDRESS

CERTIFICATE NUMBER

Complete for all dependants being claimed for on this form

NAME	RELATIONSHIP (Spouse, son, daughter, etc.)	DATE OF BIRTH YR MM DD	If child is aged 21 or over, please indicate if full time student and submit confirmation of enrolment.
			Student <input type="checkbox"/> Handicapped <input type="checkbox"/>
			Student <input type="checkbox"/> Handicapped <input type="checkbox"/>
			Student <input type="checkbox"/> Handicapped <input type="checkbox"/>

Is treatment necessary due to an accident? Yes No If YES, may another person be responsible? Yes No

Do you have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently making a claim with this insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name and address of insurer/contact AND policy number: _____ _____ _____
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SERVICES

PATIENT NAME	DATE OF SERVICE YR / MM / DD	SERVICE TYPE: Doctor and/or hospital, etc.	DIAGNOSIS/REASON FOR TREATMENT Please note diagnosis and/or reason for each service received.	AMOUNT CHARGED

TOTAL AMOUNT CLAIMED FOR ALL SERVICES:		CURRENCY:	
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PHYSICIAN'S STATEMENT - Attach original receipts - not copies. Physician statement is required if attached receipts do not include adequate information of the illness, injury and/or for treatment received. Attach additional note if necessary.

DOCTOR'S SIGNATURE _____ **DATE** _____

DOCTOR'S NAME (PLEASE PRINT) _____

DRUGS ONLY - PLEASE USE A SEPARATE FORM FOR ADDITIONAL ITEMS, IF APPLICABLE

PATIENT NAME	DATE OF SERVICE YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED	PATIENT NAME	DATE OF SERVICE YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED

TOTAL AMOUNT CLAIMED FOR ALL DRUGS:		CURRENCY:	
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ASSIGNMENT OF BENEFITS

If you are authorizing reimbursement to another party, please complete this section:

NAME OF PARTY _____ **SIGNATURE OF PRIMARY INSURED** _____

DATE _____

		POLICY NUMBER RG4335FRW
NAME (First)		(Last)

CLAIM PAYMENT INFORMATION

MAIL CHEQUE in to above address.

DEPOSIT claim payment to my Canadian or US bank account.

For Direct Deposit Payments, a void cheque must be attached or previously put on file. ***Direct Deposit is available for policy holders maintaining a bank account located in Canada or the United States. This account must be in the currency of your policy.***

I UNDERSTAND IT IS MY RESPONSIBILITY TO ADVISE NORFOLK INTERNATIONAL OF ANY CHANGES IN BANKING INFORMATION.

I hereby warrant the truth of all statements on this form and give Norfolk Mobility Benefits Inc. permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of these claims.

SIGNATURE: _____ **DATE:** _____