



## EMERGENCY MEDICAL EXPENSE CLAIM FORM

Policy No.: <b>GFRW1062</b>	Coverage Start Date (Month/Day/Year):
Organization or School Name:	Coverage End Date (Month/Day/Year):
Name of Primary Insured:	Date of Birth (Month/Day/Year):
Name of Patient:	Date of Birth (Month/Day/Year):
Home Country:	

Make cheque payable to: (Name and Address)	Tel: (     ) Fax: (     ) Email: _____
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1. **Does the claimant have medical insurance under any other plan?**     NO     YES

Names of Policy holder (i.e. parent/spouse)	Name of Other Plan	Policy #
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2. **Are any expenses submitted as the result of an accident?**     NO     YES Provide details below, including date and location of accident:

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3. **Has the claimant had same or similar conditions in past 90 days?**     NO     YES **State when and describe:**

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4. **Please provide a diagnosis for each bill submitted.** Original bills and receipts must accompany this fully completed Claim Form for reimbursement to be made to the insured/claimant.

**NOTE TO MEDICAL PROVIDERS: MAIL this signed form directly to Norfolk Mobility Benefits Inc. for prompt reimbursement. If claim is for a stable, chronic condition, have the insured pay for this visit. Questions-Please call in North America 1-866-767-5928.**

Date of Service m/d/yyyy	Service Provider	Diagnostic code and/or explanation of URGENT claim/diagnosis	Cost of Service

Prescription given     X-ray Ordered     Lab Work Ordered     Other \_\_\_\_\_

Doctors Name <b>PRINT</b>	Date	Dr.'s Signature (only required if Dr. submits for direct payment)
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I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I authorize any hospital, physician, other medical provider or insurer to provide by any means (including fax, mail or email) my complete medical records to Norfolk Mobility Benefits for the purpose of administering claims.

Signature Patient (If Minor, signature of parent or legal guardian)	Date (Month/Day/Year)
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**Attach all ORIGINAL bills and mail to:**  
 Norfolk Mobility Benefits Inc.  
 1100, 940 – 6<sup>th</sup> Avenue, S.W.  
 Calgary, Alberta, Canada T2P 3T1

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM FORM TO THE NAMED MEDICAL PROVIDER AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.