3131 Saint-Martin Blvd. West, suite 410
Laval QC H7T 2Z5
Toll Free: 1-800-387-8244
Fax: 905-821-8963
info@lewer.ca

CLAIM FOR EXTENDED HEALTH BENEFITS

Name of Employee	Certificate Number	Home Phone Number
Home Address		
Name of Employer	Address of Employer	Business Phone
Are any benefits or services provided under any other group insurance? ☐ YES ☐ NO	If yes, Name of other Insuring Agency	Policy Number

Is this claim for a dependent and/or spouse? ☐ YES ☐ NO
If "YES", complete information. School Information is required only for children age 19 or over.

Dependent's First Name (Add Surname if Different)	Date of Birth Mth	Day	Yr	Relationship to Insured	Name of School Last Attended on a Full Time Basis	Last Attended Mth	Day	Yr

CLAIM DETAILS

NAME OF CLAIMANT	PROVIDER OF SERVICE	TYPE OF SERVICE	DATE OF SERVICE	NATURE OF ILLNESS	AMOUNT CHARGED

I certify that the answers to the above questions are full and true to the best of my knowledge and that the enclosed original receipts (which will not be returned or retained by the Company) represent a claim for services rendered to myself and/or eligible members of my family.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Assumption Life and the Lewer Canada Ltd., any such information.

A photographic copy of this authorization shall be valid as the original.

Employee's Signature: _____ Date: _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL