CANADIAN BENEFIT PROVIDERS

ASSIGNMENT OF BENEFITS

PART 1 | PLAN MEMBER INFORMATION

PLAN SPONSOR/GROUP NAME			
PLAN MEMBER NAME (Last Name, First Name)		DATE OF BIRTH (mm/dd/yyyy)	
GROUP #		MEMBER ID #	

PART 2 | PATIENT INFORMATION

PATIENT NAME (Last Name, First Name)	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (mm/dd/yyyy)	RECEIPT AMOUNT

PART 3 | SUPPLIER INFORMATION

SUPPLIER NAME					
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PHONE		FAX			
IF APPLICABLE, DEGREE AND REGISTRATION NUMBER OF PRACTITIONER					

PART 4 | AUTHORIZATION

I certify that the information in this form is true and complete to the best of my knowledge. I authorize the release and exchange of information on behalf of my myself, my spouse/common law spouse and/or my dependants solely for the purposes of determining group benefits eligibility and validating claims according to the terms of this Group Insurance Plan. I recognize that my personal information is confidential and will be kept in a private Group Benefits health file and that I have the right to request access to this file, and where appropriate have any inaccurate information corrected. I am aware that if sending a scanned or faxed claim, original receipts must be kept for a period of 1 year and that in the event of an audit, the receipts must be provided within 30 days.

PLAN MEMBER'S SIGNATURE	DATE (mm/dd/yyyy)

SUPPLIER'S SIGNATURE	DATE (mm/dd/yyyy)

Forward this completed form by email, fax or mail to:
Email | claims@cbproviders.ca Fax | 1.844.944.9168
Mail | Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada

Questions? Call us at 780.944.9166 or toll free at 855.944.9166