Shield Medical Inc.

210, 10220 - 156 Street, Edmonton, AB T5P 2R1
Phone (780) 488-6899 Fax (780) 488-2269
Toll Free (888) 606-0510
info@shield.ca

BENEFITS CLAIM FORM

Employer	Employer Location (City/Prov/PC)		
Employee's Name		Employee's Date of Birth Month Day Year	
Employee's Address P.O. Box/Street Number	City	Province	Postal Code

	First Name	Sex	Date of Birth D	M	Y	Date Expense Incurred	Name & Address of Supplier or Pharmacy	Drugs: Name or D.I.N. Other: Type of Expense	Amount Charged
EMPLOYEE									
SPOUSE									
CHILDREN									

I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my family members.

AUTHORIZATION: On behalf of myself and my eligible dependents, I authorize my employer and my group benefits provider, and any of its affiliates or reinsurers, to exchange the personal information contained on this form or any other benefit-related personal information contained in their files, now or in the future, respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used solely for the purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement.

Signature of Employee ____________________ Date ____________________

PLEASE NOTE: Complete this form and return it with expense receipts attached.