

3- HEALTH CLAIM FOR FEES FOLLOWING SERVICES RENDERED BY A HEALTH PROFESSIONAL

TO BE COMPLETED BY THE HEALTH PROFESSIONAL

Patient's name: _____ Age: _____ Relationship to participant: _____

Diagnosis or nature of the evaluation: _____

Description of given treatments: _____

Prescribed medication: _____

Is it as a result of an industrial accident: Yes: Date _____

No

Is it as a result of a motorized vehicle accident: Yes: Date _____

No

MONTH	YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Detailed fees		

Professional's seal

_____ Total fees: \$ _____
Name of the association

Health professional signature: _____ Phone No.: _____ Licence No.: _____

4- CLAIM FOR ANY OTHER COSTS INCLUDING EYE CARE IF COVERED IN YOUR POLICY.

Please indicate below medical services which are not included in Sections 1 or 3 and give a short description of the reason of these costs. For eye care please attach a copy of your actual prescription and the precedent when your policy covers reimbursement following a change of sight.

5- DECLARATION AND SIGNATURE

I declare that the information given above is complete and accurate. I authorize the hospital or the professional who rendered the treatments, or any other person concerned, to provide La Capitale Insurance and Financial Services Inc. with all necessary records or information.

Date: _____ Signature of participant: _____ Phone No.: _____