



**FORM 07WC
Extended Health Care Claim Form**

Your ACCOUNT NUMBER

4501

INSTRUCTIONS - How To File Your Claim

- For Extended Health Care claims, please complete this form. Remember to include **original** receipts for all expenses.
- For dental claims, do not use this form. Submit the Standard Dental Claim form provided by your dentist.
- **Please fully complete Sections 1, 2 and 3, and be sure to sign the claim form (Section 4) before sending to AFBS.**

SECTION 1 - Member Information (please print)

MEMBER NAME (Last, First, Middle Initial)	DATE OF BIRTH
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SECTION 2 - Claim Details Insured Code: Member=00 Spouse/Partner=01 Dependant Child=02

INSURED CODE (00, 01, or 02)	INSURED'S NAME	DATE OF BIRTH	TYPE OF EXPENSE	DATE OF SERVICE	AMOUNT OF RECEIPT

PLEASE NOTE: Paper claim submissions of less than \$20.00 will be held and only released with subsequent claim(s) submissions or until the end of the Benefit Year, whichever comes first.

TOTAL

SECTION 3 - Co-ordinating with Other Insurers

Are you or your spouse/partner or dependants covered under any other plan for the expenses being claimed?
 Yes No

If Yes, please provide the following information:

NAME OF INSURED UNDER THE OTHER PLAN (Last, First, Middle Initial)	DATE OF BIRTH	
NAME OF OTHER INSURANCE COMPANY		
PLAN / POLICY NUMBER	CERTIFICATE / IDENTIFICATION NUMBER	EFFECTIVE DATE





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SECTION 4 - Authorization

I/we understand that Actra Fraternal Benefit Society may check the accuracy of the information given in support of my claim.

I/we certify that all goods and services being claimed have been received by me or my insured dependants. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I/we authorize Actra Fraternal Benefit Society, its agents and service providers to use and exchange information about me needed for underwriting, administration and adjudicating of claims under this program with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this program is audited.

I/we agree that a photocopy or electronic version shall be as valid as the original.

CLAIMANT/INSURED OVER AGE 18 SIGNATURE (required)	DATE
MEMBER'S SIGNATURE (required, if different from above)	DATE

SECTION 5 - Contact Information (Help us stay in touch with you)

IF YOU HAVE MOVED OR ARE PLANNING TO MOVE, PLEASE COMPLETE THIS SECTION.

NAME (Last, First, Middle Initial)		
NEW STREET ADDRESS	EFFECTIVE DATE	
CITY	PROVINCE	POSTAL CODE
E-MAIL ADDRESS	HOME TELEPHONE	ALTERNATIVE TELEPHONE (BUSINESS/CELL)

Important Information

To assist us in meeting our commitment to provide accurate and timely reimbursement, we require that this form be completed fully and must be signed and dated. If you are claiming for medical supplies or services that require a recommendation from your Medical Doctor, please include the recommendation with your first submission.

The recommendation must be provided each Benefit Year and clearly show the condition for which treatment is prescribed, and the name, address and telephone number of your Medical Doctor.

AFBS is committed to protecting the confidentiality of the personal information we collect from you and will use this information to assess your claim and administer the Writers' Coalition Insurance Program.

Please Send Your Completed Form To:

Actra Fraternal Benefit Society, 1000 Yonge Street, Toronto, ON M4W 2K2

Underwritten by:

Actra Fraternal Benefit Society: 1000 Yonge Street, Toronto, Ontario M4W 2K2

Telephone: (416) 967-6600 / Toll Free: 1-800-387-8897 Fax: (416) 967-4744 / Toll Free Fax: 1-888-804-8929

E-mail: writerscoalition@actrafrat.com Website: www.writerscoalition.com

