OTIP RAEO®

OTIP Health Claims
PO Box 280
Waterloo ON N2J 4A4

1.866.783.6847 | www.otip.com

Extended Health Benefits Claim

Reset

INSTRUCTIONS: (Please print all answers.)

1. All sections to be completed by the plan member unless otherwise indicated.
2. Original receipts must be attached for all expenses. (Please attach to the back of this form.)
3. Please retain copies for your files as original receipts will not be returned.
4. Please send the completed and signed form with the original receipts to the mailing address (Section 8) on the back of this form.

SECTION 1: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Gender ☐ Male ☐ Female
Address (Number, Street and Apt.)		City/Town	Province / Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*	Plan Sponsor
OTIP Identification Number	Health and Dental Policy Number	Email Address	

1. Is this a Workplace Safety and Insurance Board case (WSIB)? ☐ Yes ☐ No
2. Is your claim a result of an accident? ☐ Yes ☐ No

If answer is "Yes" to Question 1 or 2 above, give explanation, including a brief description of illness or injury and where and when injury occurred:

3. Are you, your spouse or dependants covered under any other plan for the expenses being claimed? ☐ Yes ☐ No

If "Yes", please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier.

If this is your first claim, or if information has changed, please provide the following information:

Spouse's Date of Birth (mm/dd/yyyy)	Spouse's Plan Number	Spouse's Certificate Number	Spouse's insurance Company Name

SECTION 2: PATIENT INFORMATION (Complete for all expenses. Use one line per patient.)

Patient's Name	Date of Birth (mm/dd/yyyy) (1st claim only)	Relationship to Plan Member (1st claim only)

SECTION 3: PRESCRIPTION DRUG EXPENSES

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the Drug Identification Number (DIN), the name of the prescription drug and the quantity.
- You are not required to list this information on this form.

SECTION 4: PRACTITIONER'S/PARAMEDICAL EXPENSES (e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses, please attach an itemized statement and/or receipt stating:

- patient name
- name of practitioner
- type of practitioner
- date of service
- length of visit
- charge for treatment
- date last paid by provincial plan (if applicable), and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

PLEASE COMPLETE THE BACK OF THIS FORM.

SECTION 5: EQUIPMENT AND APPLIANCE EXPENSES

For equipment and appliance expenses, OTIP requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item:

Duration equipment is required - From: _____ To: _____
Date *(mm/dd/yyyy)* **Date** *(mm/dd/yyyy)*

Has rental equipment been returned? ☐ Yes ☐ No

SECTION 6: VISION CARE EXPENSES

Please enclose an itemized receipt indicating: patient's name, cost of contact lenses, cost of glasses, dispensing fee, cost of eye exam, date of eye exam, cost of tinting, treatment, and date dispensed.

Medically necessary contact lenses

- Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ☐ Yes ☐ No
- Can visual acuity be improved at least two lines on the Snellen chart over the best possible vision with glasses? ☐ Yes ☐ No
- Could visual acuity be improved up to the 20/40 level by glasses? ☐ Yes ☐ No

_____ _____
Signature of Supplier **Date** *(mm/dd/yyyy)*

SECTION 7: CERTIFICATION AND AUTHORIZATION (ORIGINAL RECEIPTS MUST BE ATTACHED FOR ALL EXPENSES)

Total amount of ALL receipts submitted $_____

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. I authorize OTIP and the group benefits insurance carrier ("Insurer") that provides my benefits coverage to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

_____ _____
Signature of Plan Member **Date** *(mm/dd/yyyy)*

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file.

Access to your Information will be limited to:

- The Insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

SECTION 8: MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.
OTIP Health Claims
PO Box 280
Waterloo ON N2J 4A4

QUESTIONS?

OTIP Benefits Services
1-866-783-6847

Direct Deposit

Receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Visit www.otip.com and log in. Once you have logged in to the Plan Member Secure Site (also known as 'My Claims'), choose **My profile** from the top navigation, then **Update banking information.** First-time users, you will need to complete registration.