AGA BENEFIT SOLUTIONS

Submit your claims online:
https://adherents.aga.ca/en

HEALTH INSURANCE CLAIM

3500 de Maisonneuve Blvd West, Suite 2200
Westmount QC H3Z 3C1

Insured's name	Certificate No.
Complete address : No. _____ Street _____ Apt. _____	
City _____ Province _____ Postal code _____	
Telephone (_____) _____ Email address : _____	
Employer/Policyholder name	Group/Division No.

☐ **YES**, I would like to receive my claims reimbursements directly into my bank account.
You must attach a « VOID » cheque

Dependent's names (Last name/First name)	Sex	Nature of relationship	Date of birth (Y / M / D)	Covered by another plan (Yes / No)

If one of your dependents is covered by another plan, complete the « Coordination of benefits » section.

If one of your dependents is a student, complete the « Confirmation of student status » section.

Do these expenses or part of them result from work accident ? ☐ YES ☐ NO

Do these expenses or part of them result from a car accident ? ☐ YES ☐ NO

Submit expenses not covered to my Health Spending Account or Cost-Plus: ☐ YES ☐ NO

Submit any amount not reimbursed to my Health Spending Account or Cost-Plus: ☐ YES ☐ NO

COORDINATION OF BENEFITS

Dependent's name(s)		Name of the insurance company		Policy No.
Name of the policyholder (insured person)	Date of birth (Y / M / D)	Relationship	Coverage : ☐ Health insurance ☐ Dental care ☐ Individual ☐ Family ☐ Single parent ☐ Couple	
Dependent's name(s)		Name of the insurance company		Policy No.
Name of the policyholder (insured person)	Date of birth (Y / M / D)	Relationship	Coverage : ☐ Health insurance ☐ Dental care ☐ Individual ☐ Family ☐ Single parent ☐ Couple	

If the present claim has been submitted in part or in whole to another insurer, a copy of the bills as well as a copy of the settlement made by other insurer must be appended to the present document

CONFIRMATION OF STUDENT STATUS

(for your dependent child aged 21 or more, single and full-time student)

I CONFIRM THAT :

Name of the child (child has to be single)	Date of birth (Y / M / D)
Name of the school, college or university	☐ Full-time student ☐ Part-time student ☐ Autumn semester (September) ☐ Winter semester (January)

Authorization : I authorize any health care professional, any health care provider, any other insurer, the C.S.S.T. or the Workers Compensation Board, any public or private health care establishment, any government organization involved with offering health care or social services to release and exchange information requested by the insurer or AGA FINANCIAL GROUP INC. (AGA BENEFIT SOLUTIONS) and deemed necessary for processing my claim.

Insured's signature :	Date :

Receipts will not be returned