Extended Health Care (EHC) Claim Form

Claims can be submitted directly by login into the Plan Member website www.rwam.com or through the RWAM Mobile App.

EMPLOYEE STATEMENT

Employer	Group #	Div.	Class	Certificate #

Employee Name	Date of Birth (yyyy/mm/dd)	○ Male ○ Female

Employee Address #, Street	City, Prov.	Postal Code
	select	

TOTAL EACH TYPE OF EXPENSE FOR EACH CLAIMANT ON A SEPARATE LINE - Attach a receipt for each expense listed

Claimant's First Name	Relationship	Date of Birth Day Mo. Yr.	Type of Expense i.e. Drugs, Vision, Practitioner, etc.	Date Expense Was Incurred	Total Amount Charged
				TOTAL	0.00

Is this claim for a work-related accident or sickness on yourself or your dependent(s)?	○ No	○ Yes			
If 'Yes', has a claim been submitted to WCB/WSIB?	○ No	○ Yes			
If this claim is for a dependent, is the dependent employed?	○ No	○ Yes	○ If 'Yes'	☐ Full-time	☐ Part-time
If 'Yes", indicate name and address of dependent's employer					
Does the claimant have any other group health coverage?	○ No	○ Yes			
If 'Yes', indicate the name of the employer and the insurance company					

Falsifying or tampering with claim documents/receipts could have legal consequences.

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim.

Please do not use this form for emergency Out-of-Province/ Out-of-Canada (OOC) claims.

All OOC claims must be submitted directly to Allianz Global Assistance, which administers & services RWAM's Travel Assist plan.
Allianz's claim form can be downloaded at: www.rwam.com – Plan Member/Forms/Out-of-Canada

AUTHORIZATION

I certify that the expenses listed above (the receipts for which are attached) were incurred by myself or by my eligible dependent(s). The expenses were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true. I understand that the personal information that RWAM Insurance Administrators Inc. collects will be used for the purpose of determining eligibility for the benefits claimed under my policy/plan, and for validating, administering, and processing my claim. Our Privacy Policy is available at: www.rwam.com . I authorize the release and/or exchange of any information relating to this claim to or by RWAM and to or by any other parties, as may be required to administer, process, and confirm the validity and/or accuracy of this claim. If I am claiming for my eligible dependent spouse/child, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and exchange of their personal information for the same purposes. This authorization shall remain valid for as long as I am claiming benefits or service, or until revoked in writing by myself.

A photocopy, facsimile transmission or scanned copy of this authorization shall be considered as valid as the original.

_____ Signature of Employee	Date	
	Phone	

Send completed form to: web-groupclaims@rwam.com

Attention: Health Claims Department
RWAM Insurance Administrators Inc.
49 Industrial Dr., Elmira, ON N3B 3B1