C1329
Employment Health Benefit Reimbursement/Declaration

Please print clearly or type.	WCB Claim Number	Personal Health Number	Date of Accident

Worker's Surname	First Name	Initial

Worker's Mailing Address	Phone

Relationship to Claimant *(check one)*	**First Name**	**Last Name** *(if different from above)*	**Birthdate** *(yyyy/mm/dd)*
☐ **Self**			
☐ **Spouse/Partner**			
☐ **Dependent**			
☐ **Dependent**			
☐ **Dependent**			

Other Coverage

Expenses should be submitted to all other insurance companies you, or your family, have coverage through first.

Are you or your dependents entitled to receive comparable benefits from any other insurance company or health benefits company? ☐ Yes ☐ No

Name of insurance company or other health benefits company or, if other coverage, name of employer.

Name of Insured / Subscriber:	
Date of Birth (yyyy/mm/dd):	
Policy Identification Number:	
Effective Date (yyyy/mm/dd):	
Cancellation Date (yyyy/mm/dd):	

Please attach your receipts OR if this claim has been submitted under another plan first, please attach the Explanation of Benefits from that plan <u>and</u> copies of the receipts.

Please write the worker's name and claim number on each receipt.

These expenses should not relate to your work related injury.
If you have expenses that are related to your work injury, please contact us:
780-498-3999 (in Edmonton) 1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)

Worker's (Surname)	(First name)	(Initial)	Claim Number

Description of Reimbursement Requested

Enter details for each request below.

Date of Service (yyyy/mm/dd)	Service Description or Prescription Number	Total cost of the Service or Prescription	Amount paid by other Insurance Company(s)	Amount Claimed *

Amount claimed should not exceed original coverage provided by your date of accident employer.

I/we certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above named individuals. I/we acknowledge that the submission of false of incomplete information may result in the delay or denial of these expenses and recoverable overpayments.

I/we authorize WCB to collect, use and disclose information about me, and if applicable, my spouse/partner and/or dependents needed for underwriting, administration and adjudicating expenses under this claim to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I/we also understand that information pertaining to this claim may be reviewed in the event of an audit.

I/we have read and understood this form and certify that has been fully completed. I/we agree to the acknowledgement and consent on this form.

Date (yyyy/mm/dd) _____

Signature of worker _____

Please print name here _____

Signature of co-applicant / spouse _____

Please print name here _____

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

How to claim for your extended health benefit expenses

Worker's (Surname)	(First name)	(Initial)	Claim Number

To ensure the prompt handling of your expense claim, please follow these instructions:

1. **Please speak to your case manager about any of your claim-related expenses.** This form is for extended health benefits expenses only. You don't have to submit a claim every time an expense occurs. You may hold on to your expense receipts until they represent a significant amount. *Please note: you must submit all of your receipts within one year of your work-related accident or illness in order for them to be eligible for reimbursement.*

2. **If you have other coverage, please use it first.** If you, your spouse or dependents are covered under another medical plan, please submit your expenses to that plan(s) first. Please include a copy of the receipts and the Explanation of Benefits from the other plan with this form.

3. **It's your responsibility to know the benefits you're eligible for through your plan.** By signing this form, you're declaring that the information you're providing us related to these expenses are true and accurate. You must only claim your out of pocket expenses. These are expenses that would have been covered through your original employment health benefits and are not covered by any additional insurance coverage you or your family have. Any overpayments created due to inaccurate claims will be collected from any of your future benefits.

4. **We require the same statements from the referring physicians for certain medical services/expenses as your original employment health plan required.**

5. **Please make sure you have clearly filled in all of the information and signed the form.** All sections must be completed before your claim can be processed. Incomplete forms will delay the processing of your expenses.

Please mail or fax your form to:

Workers' Compensation Board - Alberta
PO Box 2415
Edmonton AB T5J 2S5

Fax: 780-427-5863
Fax (in Alberta): 1-800-661-1993

Questions?

If you have questions about your expenses or filling out this form, please contact us toll-free at 1-866-922-9221.