Quikcard

V2023113020

CLAIM FORM – For Out-of-Country Claims

INSTRUCTIONS: Attach detailed receipts for all expenses, sign, and date form. Credit card receipts and or debit slips alone are insufficient.	**IMPORTANT:** This claim form will be returned if incomplete or unsigned.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to claims@quikcard.com.

1. Cardholder Information

Name _____ Group # _____ Certificate # _____ Date of Birth D/M/Y _____

Address _____ City _____ Province _____ Postal Code _____

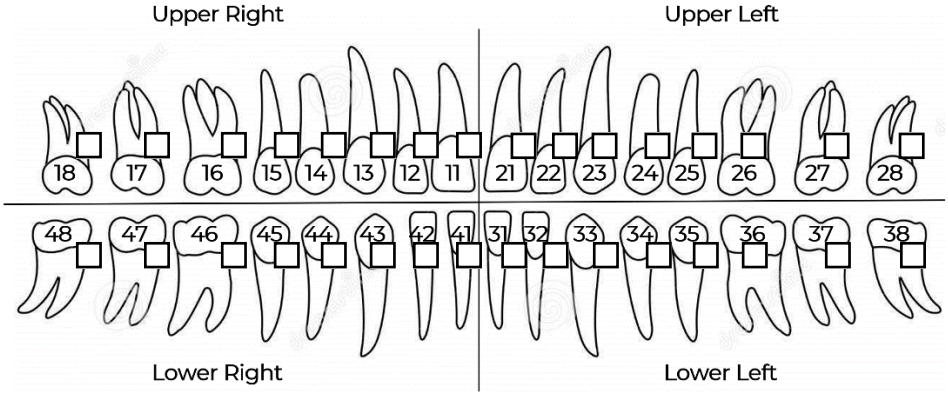
2. Patient Information *(if not the cardholder)*

Name _____ Date of Birth D/M/Y _____ ☐ Spouse ☐ Dependent

3. Dental Claims *(Please keep a copy of this form and receipts for your records)*

Date of Service	Dental Procedure	Country	Currency	Fee Amount

Please mark which tooth/teeth that the procedure was completed on:



4. Vision/Health/Drug Claims *(Please keep a copy of this form and receipts for your records)*

Date of Service	Nature of Expense	Country	Currency	Fee Amount

If additional space is needed, attach a separate page to this claim form

5. Coordination of Benefits

Was this treatment covered by any other plan? ☐ Yes ☐ No

If yes, name of the other insurer

***Please provide a copy of their payment statement**

6. Disclaimers

PRIVACY NOTICE: The information requested in respect of this claim is required by Quikcard for benefits administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information, consult Quikcard's privacy policy or contact Quikcard by phone or mail.

AUTHORIZATION: I authorize for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Quikcard, all personal health information or any other information or records in its possession that is requested while and for the purpose of administering this claim. A photocopy of this authorization shall be as valid as the original.

SERVICES MEDICALLY REQUIRED: I declare that the health services claimed on this form are medically required and not of a cosmetic nature.

PRODUCTS OR SERVICES RECEIVED: I declare that the products or services listed on this claim have been received in full.

CLAIMANT'S STATEMENT: I declare that the information contained on this claim form is true and complete to the best of my knowledge and belief. I am authorized to provide and receive the personal information of my spouse and dependants to submit this claim and for benefits administration purposes and to give the authorization set out below on my own and any of their behalf.

Signature of Cardholder _____ Date _____