



# SACB-HDP

HEALTH & DENTAL CLAIM FORM – Contract: 165069

## SECTION 1 – Member Information (Student)

Member Name (Last Name, First Name):		Certificate Number:
Address:		Apt.:
		Telephone Number:
City:	Province:	Postal Code:

## SECTION 2 – Patient Information

Patient Name (Last Name, First Name):		Date of Birth (dd/mm/yyyy):		
Relationship to Member:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Dependent Child <input type="checkbox"/>	Accompanying Person <input type="checkbox"/>

## SECTION 3 – Authorization

Note: If payment is to be made to the member, sign this section only. (Provider assignment in section 4.)

الرجاء الإمضاء على هذا القسم إذا كان الدفع مباشرة للمبتعث.

**Certification:** I, the undersigned, certify that the information I am submitting to the Cigna Life Insurance Company of Canada ("Cigna") in support of my claim, is true and complete, to the best of my knowledge and belief. I understand that Cigna may investigate my claim by collecting additional relevant personal information from me and if required, from third parties.

**Authorization:** I authorize, for a period of not less than twelve (12) and not more than twenty-four (24) months from the date hereof, any employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Cigna, or its representatives, all medical or benefit payment information or any other information or records in its possession that Cigna may hold or request while administering this claim. I agree that a photocopy of this authorization shall be as valid as the original.

Date: \_\_\_\_\_ Member Signature: \_\_\_\_\_

## SECTION 4 – Provider Information (To be completed by provider)

Provider Name:	Specialty:
Address:	Postal Code:
Provider I.D. Number:	Telephone Number:

Note: If payment is to be made to the provider, the member is to sign this section only.

الرجاء الإمضاء على هذا القسم إذا كان الدفع مباشرة الى مقدم الخدمة.

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Date: \_\_\_\_\_ Member Signature: \_\_\_\_\_

## SECTION 5 – Statement of Services (To be completed by provider)

Service Date	Description of Service	Provincial Code (plus time units, if applicable)	Charge	Diagnosis

I declare that the above is a correct statement of services rendered.

Date: \_\_\_\_\_ Provider's Signature: \_\_\_\_\_

Note: \*Physicians and Hospitals must provide the diagnosis.

\*Dentists: a Standard Claim Form is preferred, complete with codes for services rendered.

**DIRECT ALL CLAIMS AND INQUIRIES TO:**

SACB-HDP Claims Administrator  
700-1420 Blair Place  
Ottawa (ON) K1J 9L8  
Email: [clients@sacb-hdp.com](mailto:clients@sacb-hdp.com)  
Tel.: 1-888-663-6623 Fax: 613-741-7771