AMA Health Benefits Trust Fund

ALBERTA MEDICAL ASSOCIATION
ADIUM Insurance Services Inc.

Cost-Plus Plan Claim Form

PLEASE REFER TO THE *"GUIDE TO SUBMITTING COST-PLUS PLAN CLAIMS"* BEFORE SUBMITTING YOUR COST-PLUS PLAN CLAIM.

- The Cost-Plus Plan may be used to claim health or dental expenses incurred by you and/or your dependents and any employees, if applicable. These expenses must meet the Canada Revenue Agency's (CRA's) tax deduction guidelines for eligible expenses.
- **It is your responsibility to determine if your medical expenses are allowable under CRA's rules and guidelines.**
- This form may also be used to claim the participant amount of co-insurance or amounts over the plan maximum (i.e., amounts not covered by Alberta Blue Cross which are "eligible expenses" under CRA guidelines) by submitting the "Explanation of Benefits" statement you receive from Alberta Blue Cross after submitting a claim. It is not necessary to include copies of the receipts, but please keep copies for your records or if we should request copies.

PARTICIPANT INFORMATION [Physician or Employee claiming medical expenses]

SURNAME	GIVEN NAME AND INITIALS		AMA #
STREET ADDRESS	CITY/TOWN	PROVINCE	POSTAL CODE

PARTICIPANT DECLARATION AND AUTHORIZATION

I certify that all goods or services being claimed have been received by me or my dependents. I certify that the information in this form is true and complete, to the best of my knowledge. By submitting this claim form, I understand that I am requesting payment be made for the expenses submitted, in accordance with Cost-Plus Plan claiming guidelines. **I accept full responsibility to ensure that all expenses incurred and submitted are allowable medical expenses as defined under CRA's guidelines.** I understand that the personal information provided herein, as well as any other personal information currently held by the Alberta Medical Association (AMA) about me and my eligible dependents will be used to verify, determine eligibility for, and pay claims under this benefit. I authorize any health care provider, Alberta Blue Cross, or other relevant person to release or exchange information if required by the Trust Fund or its Administrators to process this claim. I understand that my personal information will be kept confidential and secure in accordance with the AMA's privacy policies and procedures. I agree that a photocopy of this authorization shall be as valid as the original.

_____
SIGNATURE OF PARTICIPANT *(physician/employee)*

_____
NAME OF PARTICIPANT *(please print)*

PAYOR AUTHORIZATION

The undersigned hereby authorizes the AMA Health Benefits Trust Fund Administrators to pay the eligible health and/or dental expenses through the Cost-Plus Plan for the above-named participant.

_____
SIGNATURE OF SPONSORING PHYSICIAN OR AUTHORIZED SIGNATURE

_____
SPONSORING PHYSICIAN OR CORPORATION *(please print)*

CLAIM INFORMATION

NAME OF PERSON FOR WHICH EXPENSE WAS INCURRED	RELATIONSHIP TO PHYSICIAN OR EMPLOYEE	DATE OF SERVICE (YYYY/MM/DD)	DESCRIPTION, E.G., RX, DENTAL, VISION	AMOUNT CLAIMED FROM TRUST FUND
			ADMINISTRATION FEE	$25.00
			TOTAL CLAIM (CHEQUE ATTACHED FOR FULL AMOUNT)	

Mail to: AMA Health Benefits Trust Fund, CMA Alberta House, 12230 106 Avenue NW Edmonton AB T5N 3Z1