OpenCircle BENEFITS

GENERAL CLAIM SUBMISSION FORM

Please use one form per patient, per practitioner

INSTRUCTIONS

1. Complete page 1 and 2 of this form.
2. Attach all original receipts and supporting documentation.
3. Retain copies for your files as originals will not be returned.
4. Send to the appropriate department, see Mailing Instructions.

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?
Go to mybenefitsconnect.opencirclebenefits.ca for more details

PAYMENT INFORMATION - Completion of this section is required. Please check the appropriate box below confirming who will be receiving payment.

☐ REIMBURSE PROVIDER	☐ REIMBURSE PLAN MEMBER
THE CHARGES INCLUDED WITH THIS CLAIM HAVE NOT BEEN PAID IN FULL. IF PERMITTED BY MY PLAN, I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM AND AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER.	I CERTIFY THAT THE CHARGES INCLUDED WITH THIS CLAIM HAVE BEEN PAID IN FULL AND I HAVE ATTACHED ALL ORIGINAL RECEIPTS AND SUPPORTING DOCUMENTATION REQUIRED.
_____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN	_____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN
IF SELECTED, PROVIDER INFORMATION BELOW MUST BE COMPLETED BY PROVIDER	IF SELECTED, PLEASE SKIP TO PLAN MEMBER INFORMATION BELOW

IF THE ABOVE IS LEFT BLANK, PAYMENT WILL AUTOMATICALLY BE REIMBURSED TO PLAN MEMBER

PROVIDER INFORMATION - This section must only be completed if you have selected Reimburse Provider in the Payment Information above.

PROVIDER NUMBER	PROVIDER EMAIL ADDRESS	
PROVIDER NAME	PROVIDER PHONE #	
PROVIDER ADDRESS		
CITY	PROVINCE	POSTAL CODE

THE ABOVE IS TO BE COMPLETED BY THE PROVIDER ONLY

PLAN MEMBER INFORMATION - Completion of this section is required. Please ensure that you always provide your Plan Member ID in full, including suffix (ie. 00, 01, etc.). If you are unsure of your Plan Member ID, please refer to your Benefit ID Card.

PLAN MEMBER ID		EMAIL ADDRESS
SURNAME	FIRST NAME	PHONE NUMBER
ADDRESS		COMPANY NAME
CITY	PROVINCE	POSTAL CODE

PATIENT INFORMATION - Completion of this section is required.

PATIENT'S NAME	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY

MANDATORY DECLARATIONS - Completion of this section is required. Please use this section to indicate if you were involved in a Motor Vehicle Accident or Workplace Injury.

MOTOR VEHICLE ACCIDENT

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, include date of accident _____

Include which expenses are MVA related _____

WORK RELATED INJURY

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, include date of injury _____ WCB Case # _____

Include which expenses are a result of the work related incident _____

COORDINATION OF BENEFITS - Completion of this section is required by the Plan Member. Please use this section to indicate if you or any member of your family have benefits coverage from any other insurance plan and/or have a Health Care Spending Account or a Health Executive Spending Account. (*NOTE: Payment from HCSA and HXSA can only be paid to the Plan Member.*)

Do you have any other group insurance coverage that may include these services as benefits? YES ☐ NO ☐

If we are your secondary carrier, please attach copies of your receipt and your Explanation of Benefit statement from your primary carrier.

If other coverage is with OpenCircle Benefits, indicate other Plan Member ID: _____

Do you want to coordinate this claim with your other OpenCircle Benefits? YES ☐ NO ☐

HEALTH CARE SPENDING ACCOUNT (HCSA)

Do you want to coordinate these claims with your Health Care Spending Account (if applicable)? YES ☐ NO ☐

If yes, include which claims are to be coordinated with HCSA _____

I want all my eligible expenses paid directly from my Health Care Spending Account (if applicable)? YES ☐ NO ☐

If yes, include which claims are to be processed under HCSA _____

PERSONAL SPENDING ACCOUNT (PSA) / HEALTH EXECUTIVE SPENDING ACCOUNT (HXSA)

I want all my eligible expenses paid directly from my Personal Spending Account / Health Executive Spending Account (HXSA) (if applicable)? YES ☐ NO ☐

If yes, include which claims are to be processed under PSA / HXSA _____

At OpenCircle Benefits ("**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of OpenCircle Benefits, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); OpenCircle Benefits's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at https://opencircle.ca/privacy-policy/, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on https://opencircle.ca/privacy-policy/. You can contact our Privacy Officer at inquiries@opencirclebenefits.ca if you have a question or complaint.

By signing below, you are providing your consent to OpenCircle Benefits's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to OpenCircle Benefits at inquiries@opencirclebenefits.ca, but, if you do so, OpenCircle Benefits will no longer be able to administer your benefits plan and process your claims.

Name	Signature	Date

MAILING INSTRUCTIONS- Please send your claim to the corresponding address below (be sure to indicate the full address on the envelope). To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed below.

All claims for health and dental for a given calendar year must be received by June 30 of the following calendar year to be considered.
Health Care Spending Account claims for a given year are due no later than 60 days into the new calendar year.

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	DENTAL
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1608
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	N9A 7G1

Please call our Customer Service Centre at 1-877-263-7266 or (780) 455-5845 if you require any assistance in completing this form.