



**A) MEMBER INFORMATION**      **Policyholder:** \_\_\_\_\_      **Certificate Number:** \_\_\_\_\_

**Name (First, Last):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**Email Address:** \_\_\_\_\_

**Use Direct Deposit?**    Yes     No   
 If you would like your reimbursement deposited directly to your bank account, please enclose a "void" cheque.

**B) CLAIM INFORMATION**

**Number of receipts attached:** \_\_\_\_\_      **Total Amount claimed:** \$ \_\_\_\_\_

- 1) Is claim the result of a Dental Accident?    Yes     No   
 2) Is claim the result of an emergency that occurred while traveling outside province of residence?    Yes     No   
 If you have answered YES to either questions 1 or 2, please attach dates and details separately.

**C) DEPENDENT INFORMATION (INCLUDING SPOUSE)**

Name (First, Last)	Birth Date	Relationship	Gender	Student*	School Year

\* Dependents age 21 and over are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31<sup>st</sup> of this school year, the upper limit of the dependent definition age for students or until coverage is terminated. Proof of full-time status may be required at any time.

**D) CO-ORDINATION OF BENEFITS**

With Co-ordination of Benefits, you may be able to obtain reimbursement up to 100% of your eligible expenses. Please indicate coverage level, single/couple//family, the spouse/dependent may have with another insurance provider.

**Name of Family Member:** \_\_\_\_\_      **Coverage:** \_\_\_\_\_  
**Name of Family Member:** \_\_\_\_\_      **Coverage:** \_\_\_\_\_

I authorize Johnson Inc., Plan Administrator, to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Johnson Inc., will be kept confidential and, where necessary Johnson Inc. will be exchanging personal information. I authorize the following persons to exchange with Johnson Inc. or each other, any of my personal information in their possession; any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution. I acknowledge that more detailed information concerning how and why Johnson Inc. collects, uses and discloses my personal information is available at www.johnson.ca. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

**Member Signature:** \_\_\_\_\_      **Date Signed:** \_\_\_\_\_

**Please mail completed claim form and receipts to:**  
 Johnson Inc., Plan Benefits, Claims  
 1595-16th Avenue  
 Suite 700  
 Richmond Hill Ontario L4B3S5  
 1-800-638-4753 (toll free)  
 905-764-4888

