**AMA Health Benefits Trust Fund**

ALBERTA MEDICAL ASSOCIATION | ADIUM Insurance Services Inc.

# Cost-Plus Plan Claim Form

Please visit (www.albertadoctors.org/services/physicians/insurance/for-physicians/ama-hbtf) "Make a Claim" for instructions on completing this claim form.

Claims can be sent by fax, scan and email, or mail. Please see contact information at the bottom of page 2.

**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 Canada Revenue Agency's guidelines.** I acknowledge that the original receipts and supporting documentation for the expenses submitted must be kept on my file for at least four (4) years, and upon request by AMA Health Benefits Trust Fund (the "Trust Fund"), I must produce to the Trust Fund the receipts and supporting documents for these expenses. I further acknowledge that a submission of an inaccurate or potentially fraudulent claim may result in notification by Alberta Medical Association ("AMA") to the Board of Trustees of the Trust Fund, may result in notification by the Payor (if applicable), and may also result in me not being allowed to make receipt-less claims in the future. I understand that the personal information provided herein, as well as any other personal information currently held by 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 or other relevant person to release or exchange information if required by the Trust Fund or its administrators to proceed with 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.

X _____ _____

**SIGNATURE** OF PARTICIPANT (physician/employee) DATE

_____

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, by making such payment, together with the required administration fee of AMA Health Benefits Trust Fund, from my bank account, from which the Trust Fund debits Core Plan premiums.

X _____

**SIGNATURE** OF SPONSORING PHYSICIAN OR AUTHORIZED SIGNATURE

_____

SPONSORING PHYSICIAN, CORPORATION, OR CLINIC (please print)

**CLAIM LISTING**

| NAME OF PERSON FOR WHICH EXPENSE WAS INCURRED | RELATIONSHIP TO PHYSICIAN OR EMPLOYEE | DATE OF SERVICE (MM/DD/YYYY) | DESCRIPTION, E.G., Rx, DENTAL, VISION, ETC. | AMOUNT |
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| | | | **SUBTOTAL (CAD)** | $ 0.00 |
| | | | **ADMINISTRATION FEE** | $ 25.00 |
| | | | **TOTAL CLAIM (CAD)** | $ 25.00 |

**Mail to:** AMA Health Benefits Trust Fund, CMA Alberta House, 12230 106 Avenue NW, Edmonton AB T5N 3Z1
**Fax to:** 780.488.7558 or 1.877.302.3486 **Email to:** adium@albertadoctors.org

*Please ensure all expenses submitted are in Canadian funds.*

*Email and fax disclaimer: Be advised that using email or fax to send personal or confidential information is not considered a secure method of communication. Individuals who choose to use email or fax to send personal information does so at his/her own risk. Individuals may choose to use postal mail as an alternative.*

Revised: November 2020