SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

COST PLUS/EXTRA CONTRACTUAL CLAIM

PLEASE NOTE:

- Coverage is available for Plan Members who have a defined health or dental benefits plan with Saskatchewan Blue Cross. Plan Members should first submit claims through their defined plan for initial benefit consideration and provide a copy of the Explanation of Benefits statement(s) with this claim.
- Allowable expenses are determined based on eligibility under the Canadian Federal Income Tax Act.
- Eligible reimbursement will be provided to the Plan Member after payment information is received from the Plan Sponsor.

MEMBER INFORMATION AND CONSENT (PLEASE PRINT)

Policy Number	ID Number	Date of Birth (YYYY-MM-DD)

First Name	Last Name

Street Address/Box No.	City/Town	Province	Postal Code

I, the undersigned, accept full responsibility that all expenses incurred and submitted for payment under this service are allowable medical expenses as defined under the Canadian Federal Income Tax Act and acknowledge that I am responsible for the payment of any taxes that may arise from reimbursements.

I understand that the personal information I have given, as well as any other personal information currently held or provided in the future by Saskatchewan Blue Cross and/or its agents, may be collected, used, maintained and disclosed for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation, confirming my identity, maintaining my relationship with Saskatchewan Blue Cross and helping to develop and recommend suitable products and services to me.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations and/or their authorized agents/representatives, licensed physicians, practitioners or other healthcare providers, hospitals, clinics or other medical facilities, other health and life insurers and reinsurers, employers (past and present), government and regulatory authorities and other third parties only when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed, and I am aware of the risks and benefits of consenting to or refusing to consent to its disclosure. For additional information regarding the privacy policies of Saskatchewan Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853. A photocopy of this authorization shall be as valid as the original.

Signature of Member/Claimant	Date (YYYY-MM-DD)

PLAN SPONSOR PAYMENT INFORMATION

		For Saskatchewan Blue Cross Accounting Dept. Use Only
Total Allowable Expenses	$	
+ 10% Administration Fee ($25 Min./ $500 Max.) (on Total Allowable Expenses)	$	
+ 5% GST (on Administration Fee)	$	
TOTAL PAYMENT CALCULATED	$	

Cheque Enclosed? ☐ Yes ☐ No, please contact me to confirm amount of payment required

PMT Number		Processed	

PLAN SPONSOR CONTACT INFORMATION AND AUTHORIZATION

On behalf of the Plan Sponsor, I hereby authorize Saskatchewan Blue Cross to calculate and/or arrange payment for the total allowable expenses based on the information submitted and acknowledge and agree that the Plan Sponsor retains all legal and financial liability in connection with Saskatchewan Blue Cross administering this Cost Plus claim. *Cost Plus may not be tax-effective for everyone and special tax rules may apply. It is strongly advised that you consult your professional tax advisor(s).

First Name	Last Name	Title	Company Name

Signature	Phone Number	Email Address

For Saskatchewan Blue Cross Claims Department Only

	Yes	No	Notes	Initials
Cheque Enclosed	Amount:			
Covered Claimant(s)				
Authorized Signature				
Correct Payment				
Other Comments				

Authorized By	Name:	Signature:	Date: