alberta benefits ltd.

ASSIGNMENT OF BENEFITS FORM

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (Last Name, First Name)				DATE OF BIRTH (dd/mm/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | PATIENT INFORMATION

PATIENT NAME	RELATIONSHIP TO PLAN MEMBER	DATE OF BIRTH (mm/dd/yyyy)	DISABLED	FULL-TIME STUDENT	IF YES, SCHOOL
			Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	

PART 3 | SUPPLIER INFORMATION

SUPPLIER NAME					
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PHONE		FAX			
IF APPLICABLE, DEGREE AND REGISTRATION NUMBER OF PRACTITIONER					

PART 4 | AUTHORIZATION

__I recognize__ this claim may be subject to audit. Therefore __I authorize__ release of any information or records requested in respect to this claim. __I certify__ that the information in this form is true and complete to the best of my knowledge. __I authorize__ the release and exchange of information on behalf of myself, my spouse/common law spouse and/or my dependants solely for the purposes of determining group benefits eligibility and validating claims according to the terms of this Group Insurance Plan. __I recognize__ that my personal information is confidential and will be kept in a private Group Benefits health file and that I have the right to request access to this file, and where appropriate have any inaccurate information corrected.

PLAN MEMBER'S SIGNATURE	DATE (dd/mm/yyyy)

SUPPLIER'S SIGNATURE	DATE (dd/mm/yyyy)

Forward completed form to: Alberta Benefits Ltd., #202, 10235-124th Street NW, Edmonton, Alberta, T5N 1P9, Canada
TEL: (780) 944 9167, FAX: (780) 944 9168, TOLL FREE: (866) 944 9167, www.albertabenefits.com