

TEMAGAMI FIRST NATION ENRICHMENT FUNDS

Health Benefits Claim Form

This form must be signed and completed in full. **If incomplete, it will be returned to you which will delay the processing of the claim. Enclose original receipts – Copies are not acceptable.**

With Regards to this Claim:

Have you accessed First Nation and Inuit Health? Yes_____ No_____

If Yes, please attach documentation. If No, please explain why

Do you have any other group health insurance coverage available to you? Yes___ No___

If yes, have you accessed it? Yes_____ No_____ If Yes, please attached documentation.

If No, please explain why_____

Client Name:	Band Number
Mailing Address: City/Town Prov. Postal Code	Date of Birth
Email address:	Telephone: (Home or Cell)
<u>Type of Expense: *(vision, dental etc.)</u>	<u>Amount Charged</u>
	Total

I hereby certify that the above information is true and accurate.

SIGNATURE

DATE

Mail this form and *original receipts* to:

Doreen Potts Health Centre
 Temagami First Nation
 BEAR ISLAND, ON P0H 1C0

Attention: **Office Manager** Enrichment Funds Claim
 Inquiries: (705) 237-8900 or toll-free at 1-866-262-2862