Claims Submission

1. Download a **Medical Claim Form** from www.norfolkmobility.com or request it from the NMB Client Service Center at (403) 537-8823, or Toll Free within North America at 1 (866) 767-7959.

2. Complete the Medical Claim Form and **attach all original receipts and statements** for which you wish to be reimbursed.
   - If your claim is under **USD$2,500** it may be faxed or emailed to our offices to initiate processing, however the originals must be retained by you for a period of 24 months after the claim was incurred. NMB may request copies of these receipts at any time to validate your reimbursement.

3. We will not process claims over USD$2,500 until the originals are received by one of our three global claims offices.

4. **Submit all claims as quickly as possible** as mail delays can be extensive. Claims must be submitted within 365 days after the expense is incurred*.

5. **Keep a copy** of all submitted documents for your records.

Norfolk Mobility Benefits Claims Centers

North and South America

Suite 1100, 940 – 6th Avenue S.W.
Calgary, Alberta, Canada T2P 3T1
Tel: +1 403 537-8823 Fax: +1 403 265-9425
Toll Free: 1-866-767-7959
claims@norfolkmobility.com

Europe

82 rue Villeneuve
92587 Clichy Cedex, France
Tel: +33 (0) 1 44 71 50 35 Fax: +33 (0) 1 42 81 99 03

Middle East, Africa and Asia

Suite 2 Level 5 Gate Precinct, Building 4
DIFC PO Box 506537
Dubai, United Arab Emirates
Tel: +971 4 365 1308 Fax: +971 4 428 9264

*In the event of plan termination or termination of an individual employee's coverage, all proofs of claim must reach Norfolk Mobility Benefits no later than 90 days after the date of termination.

LLOYD'S **CLAIM FORM**

NORTH & SOUTH AMERICA
Norfolk Mobility Benefits Inc.
Suite 1100, 940-6 Ave SW
Calgary AB, CANADA T2P 3T1
Tel: +1 403 537-8823
Fax: +1 403 265-9425
claims@norfolkmobility.com

EUROPE
Norfolk Mobility Benefits Inc.
82 rue Villeneuve
92587 Clichy Cedex, France
Tel: +33 (0) 1 44 71 50 35
Fax: +33 (0) 1 42 81 99 03

MIDDLE EAST, AFRICA & ASIA
Norfolk Mobility Benefits Inc.
Suite 2, Level 5, Gate Precinct
Building 4
DIFC-PO Box 506537
Dubai, UNITED ARAB EMIRATES
Tel: +971 4 365 1308
Fax: +971 4 428 9264

GROUP NAME: HR Associates Limited	IMPORTANT: All claims must be received by Norfolk Mobility Benefits within 365 days after the date of service, or within 90 days after the policy has been terminated.

NAME (First): John	(Last): Doe	DATE OF BIRTH: January 1, 1960	POLICY NUMBER: GFRW0000

STREET ADDRESS: 1234 Main Street

CITY	STATE/PROVINCE	COUNTRY	POSTAL/ZIP CODE
Toronto	Ontario	Canada	M5J 1X8

EMAIL	PHONE (include country code)	CERTIFICATE NUMBER
johndoe@email.com	00 1 (403) 555-5555	911 123

Complete for all dependants being claimed for on this form

NAME	RELATIONSHIP (Spouse, son, daughter, etc.)	DATE OF BIRTH YR MM DD	If child is aged 18 or over, please indicate if full time student and submit confirmation of enrolment.
Jane Doe	Spouse	74 | 08 | 02	Student ☐ Handicapped ☐
Jeremy Doe	Son	98 | 04 | 27	Student ☐ Handicapped ☐
			Student ☐ Handicapped ☐

Is treatment necessary due to an accident? ☐ Yes ☒ No If YES, may another person be responsible? ☐ Yes ☐ No

Do you have other insurance coverage? ☐ Yes ☒ No
Are you currently making a claim with this insurer? ☐ Yes ☐ No
If yes, please provide name and address of insurer/contact AND policy number:

SERVICES (please use a separate form for additional items if required)

PATIENT NAME	DATE OF SERVICE YR / MM / DD	SERVICE TYPE: Doctor and/or dental visit, hospital, etc.	DIAGNOSIS/REASON FOR TREATMENT Please note diagnosis and/or reason for each service received.	AMOUNT CHARGED
Jane	09 | 04 | 08	Doctor Visit	Annual Checkup	$270.00
Jeremy	09 | 03 | 14	Dentist Visit	Cleaning	$145.00
	| |			
	| |			
	| |			
	| |			

TOTAL AMOUNT CLAIMED FOR ALL SERVICES:	$415.00	CURRENCY:	USD

PHYSICIAN'S STATEMENT - Attach original receipts. Physician statement is required if attached receipts do not include adequate information of the illness, injury and/or for treatment received. Attach additional note if necessary.

DOCTOR'S SIGNATURE _____ **DATE** _____
DOCTOR'S NAME (PLEASE PRINT) _____

GROUP NAME: HR Associates Limited	POLICY NUMBER: GFRW0000

NAME (First): John (Last): Doe

PRESCRIPTION DRUGS (please use a separate form for additional items if required)

PATIENT NAME	DATE OF SERVICE YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED	PATIENT NAME	DATE OF SERVICE YR / MM / DD	NAME OF DRUG	AMOUNT CHARGED
Jeremy	09 | 04 | 01	Ventolin	$27.00		| |		
	| |				| |		
	| |				| |		
	| |				| |		
	| |				| |		
	| |				| |		
	| |				| |		

TOTAL AMOUNT CLAIMED FOR ALL DRUGS:	$27.00	CURRENCY:	USD

ASSIGNMENT OF BENEFITS

If you are authorizing reimbursement to another party, please complete this section:

NAME OF PARTY _____ **SIGNATURE OF PRIMARY INSURED** _____

DATE _____

CLAIM PAYMENT INFORMATION

I UNDERSTAND IT IS MY RESPONSIBILITY TO ADVISE NORFOLK MOBILITY BENEFITS OF ANY CHANGES IN BANKING INFORMATION.

Please indicate if you would prefer to receive your claim payments via:

☒ **Cheque.** Please confirm currency of claims reimbursement: USD

☐ **Wire Transfer.** For Wire Transfer payments, please provide the bank account details as required by the receiving bank:

BANK INFORMATION
Beneficiary Bank Name _____
Bank Identification Number _____
Address of Beneficiary Bank _____
Currency of Bank Account _____
Swift Code _____

BENEFICIARY INFORMATION
Beneficiary Account Number _____
Beneficiary Name _____
Beneficiary Address _____
ABA Code (accounts in USA) _____
Swift Code (all other accounts) _____

Please note, your bank may charge you fees to receive a wire transfer. Any fees charged by the receiving bank are the responsibility of the beneficiary.

I hereby warrant the truth of all statements on this form and give Norfolk Mobility Benefits permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of these claims.

SIGNATURE: _____ **DATE:** June 1, 2009

Emergency Contact

In the event of a medical emergency, **contact your medical assistance provider immediately**. They will work 24/7 to assist you and monitor your care until the situation is resolved.

The contact information for your Emergency Medical Provider is located on your Wallet Card and within your Employee Benefit Booklet.

Your provider will require the following information when you contact them.

- Name of caller, telephone number and relationship to the patient.
- Name of the patient, age, sex and location and their certificate number (found on your/their ID card).
- Name of your organization.
- Nature of the medical problem.
- Contact information and telephone numbers of medical personnel involved.
- How and when the next communication will take place.

Pre-Authorization of Expenses

To ensure that expenses for specific services to be rendered at a future date will be covered, you may request a Pre-Authorization of Expenses from NMB.

To obtain a Pre-Authorization:

- Contact the NMB Client Service Center for a Pre-Authorization form.
- This form will need to be completed by you or your treating physician.
- Upon receipt of the completed form, NMB will issue a Pre-Authorization Letter that details the coverage available for the specific services indicated, including any maximums or limitations.

Direct Billing Between Your Provider and NMB

A Direct Billing Arrangement allows a treating facility to send the invoice directly to NMB for payment. This minimizes the possibility that you will incur large out-of-pocket expenses. Our company issues over 6,000 Direct Payment Agreements each year.

While NMB is willing to work with any medical facility to make these arrangements, the facility must also be in agreement and be willing to accept payment directly from our offices.

To arrange for a Direct Billing relationship:

- Prior to accessing services, the member may contact the NMB Client Service Center to inquire about facilities within their area with whom an agreement is already in place.
- If services are to be received in the United States, please visit www.hygeia.net and click on Public Provider Search to obtain a listing of all US facilities within our Preferred Provider network. These facilities are contractually obligated to bill NMB directly for services.
- If you wish to seek treatment at an alternative treatment facility in the U.S., contact the facility directly prior to treatment to confirm whether the facility is willing to bill directly to NMB.
- Upon confirmation that a direct billing will be accepted, the facility contact information must be provided to NMB by you or the facility.
- NMB will issue a letter directly to the facility confirming that we will pay the facility upon receipt of the invoices.

Contact Us

For assistance regarding any of the above:

Phone (collect calls accepted): 00 1 (403) 537-8823

Toll Free (within North America): 1 (866) 767-7959

Email: claims@norfolkmobility.com

NORFOLK MOBILITY BENEFITS

GROUPE SIACI SAINT HONORE

To your benefit...

QuickTips about...

Claims Submission

Emergency Contact

Pre-Authorization

Direct Billings