

How to submit **PROOF OF COVERAGE**



INFORMATION REQUIRED

Your document must clearly indicate your coverage for extended health care, the insurance company name, and the policy number.



ACCEPTABLE DOCUMENTS

- **An image** of a summary of benefits from an insurance company's website
- **A copy** of a **certificate or card**
- **A letter** from the plan sponsor (usually the employer) or the insurance company
- Aboriginal students who receive benefits from Health Canada may provide a copy of their status card.



IT'S EASY TO SUBMIT YOUR DOCUMENTS

ELECTRONIC DOCUMENTS (from a company's website)

- 1 You can use the print screen button to **capture an image** of your screen
- 2 **Copy, paste**, and save it in a **Word** document, as a **PDF**, or an **image file**, such as a tiff, gif, jpeg, or png.

PRINTED DOCUMENTS

- 1 **Scan** your letter/card OR **take a picture** with a digital camera or smart phone.
- 2 Save it in **PDF** format, **Word**, or as an **image file**.

PROOF OF COVERAGE EXAMPLES

WEB IMAGE Example

BENEFITS SUMMARY FROM A COMPANY'S WEBSITE

Date: **00/00/0000**

Participant: **Your Full Name**

Policy number: **00000000**

Coverage Summary: **Health Coverage**

YOUR INSURANCE COMPANY

YOUR COMPANY

NAME OF INSURANCE COMPANY/ LOGO

NAME OF EMPLOYER/ LOGO

HEALTH COVERAGE

YOUR NAME

YOUR POLICY NUMBER

OR

CARD Example

NAME OF INSURANCE COMPANY

YOUR POLICY NUMBER

YOUR NAME

YOUR INSURANCE COMPANY

Policy **0000000**

Your Full Name

Date of Birth

Health Plan

HEALTH COVERAGE

OR

LETTER Example

YOUR COMPANY LETTERHEAD

The Date

Re: **Your Full Name**

To Whom it May Concern:

This letter serves as confirmation that **your name** has extended **health coverage** as an employee of **the place where you work**. Our benefits provider is the **name of your insurance company** and our policy number is **your insurance policy number**.

Yours truly,

Signature of Benefits Administrator

**Your Benefits Administrator
Their Department
(Phone Number + Extension)**

YOUR NAME

NAME OF EMPLOYER

YOUR POLICY NUMBER

CONTACT INFORMATION

HEALTH COVERAGE

NAME OF INSURANCE COMPANY