

Transportation for Long-Term Care Claim Form

Claimant Information

Full Name

Date of Birth

Policy Number

Phone Number

Address

Transportation Details

Date	From	To	Purpose	Distance (km/miles)	Cost
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other Information

Additional Comments

Claimant Signature

Date

Authorized Representative (if any)

Date