

**REIMBURSEMENT REQUEST FORM FOR EXTENDED HEALTH SERVICES PROVIDED
TO POLIO SURVIVOR MEMBERS OF THE WILDROSE POLIO SUPPORT SOCIETY**

To be completed by the WPSS member unless otherwise indicated. Please print clearly. Please retain copies for your file as receipts sent to us will not be returned. Any information provided or collected will be retained in a Member Benefits confidential file.

Note: Reimbursement for services is limited to available funds and not guaranteed by the Wildrose Polio Support Society.

\$3000.00 per member per annum is available for therapy, and aids and devices, effective November 1, 2025

***Expenses must be incurred within the reimbursement year, which is November 1 to October 31.**

***Claims for reimbursement must be submitted within 6 months of the expense.**

For full details, please see Reimbursement Policy located on the website, www.polioalberta.ca

Member's First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Type of Service Provided	Date of Service	Total Charge	Amount Paid by Other Sources	Amount to be Reimbursed
			Total Requested:	

For shower and bath assists, or for specialty orders, please describe how these products will help to maintain your safety or independence at home or within the community, as a polio survivor.

I certify that these expenses meet the following conditions:

I have received all services claimed and that the information provided is true and complete, the services listed were received on the date(s) listed above, and

I have not been reimbursed for these expenses in any way.

That I have submitted proof that I am a polio survivor.

I understand that reimbursement of these expenses may only be requested after I have exhausted all benefits available from all plans through which I am covered. For aids and devices any correspondence with Aids to Daily Living and your Insurance Company (e.g. Blue Cross) must be submitted with this claim.

Member Signature _____ Date _____

Please send completed form with a copy of the invoice and receipt to:

Wildrose Polio Support Society 8640 - 64 Avenue NW Edmonton, Alberta T6E 0H5

You may email an electronic copy of the form and the receipts to wpss@polioalberta.ca

For Office Use Only

Co-Pay _____ Letter _____ Big Ticket _____ Checked _____

Membership date _____ Approved _____ Received _____

(Revised Nov. 4, 2025)