

## **Group Benefits Extended Health Care Claim**

To be completed by the plan member unless otherwise indicated. Original receipts must be provided for all expenses. Please retain copies for your files as original receipts will not be returned.

1	Plan member information	Plan contract number Plan member certificate number  Plan sponsor  Plan member name (first, middle initial, last)						
		Date of birth (dd/mmm/yyyy)						
		Plan member address (number, stree						
		City/Town	. ,					
_	Workers'							
_	compensation	Are any of the expenses associated with a work related incident AND eligible for workers' compensation benefits?   Yes  No  If yes, submit these expenses to your provincial workers' compensation board.						
_	board	ii yes, subiliit tilese expelises to your provinciai workers compensation board.						
3	Coordination of benefits	Are you, your spouse or dependants covered under any other plan for the expenses being claimed?   Yes   No  If yes, please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:						
Sp	oouse's date of birth (	dd/mmm/yyyy)	Name of spouse's insur	ance company				
Sp	ouse's plan contract	number	Spouse's plan member certificate number					
		ndary carrier, include copies of the rec						
_	Patient	Patient's name	Date of birth	Relationship to Complete if patient is a student 18 or older.				
7	information		(dd/mmm/yyyy) (1st Claim only)	plan member (1st Claim only)	School and city	If employed, hrs worked per week		
	Complete for all expenses. Use one line per patient.		_			worked per week		
_ 5	Prescription drug expenses	Include your prescription drug rece     All receipts must contain the drug     You are not required to list this info	identification number (DIN) a	and the name of the pre	escription drug.			
6	Practitioner/ Paramedical expenses (e.g. chiropractor, massage therapist, physiotherapist, etc.)	<ul> <li>patient name,</li> <li>name of practitioner,</li> <li>type of practitioner,</li> </ul>	date of service, length of visit, charge for treatment,	it, • licence and/or registration number.				
7	Equipment and appliance expenses	For equipment and appliance expenses Manulife requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).  Indicate the activities requiring the use of this item.						
Dι	uration equipment is r	equired: <b>From:</b> Date (dd/mmm/yyyy) _		<b>To:</b> Date (dd/m	nmm/yyyy)			
Ha	as rental equipment b	een returned?						

Please complete next page.

8	Vision care expenses	Please enclose an itemized rece     patient name,     cost of contact lenses,     cost of glasses,	eipt indicating:  cost of laser surgery, dispensing fee, cost of eye exam,	<ul><li>date of eye exam,</li><li>cost of tinting,</li><li>date dispensed.</li></ul>			
	TO BE COMPLE	TED BY SUPPLIER					
	If your contract covers medically necessary contact lenses, please answer the questions below:  Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia?  Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses?  Could visual acuity be improved up to at least the 20/40 level by glasses?  Yes No  Yes No						
	Signature of supplier			Date signe	ed (dd/mmm/yyyy)		
9	Banking information and email address		claim statements under the My	Plan Member secure site. Then s Profile menu OR complete this s	sign up for direct deposit and electronic section.		
		By providing your banking information, your claim pay be deposited directly to you Locate your banking inform on your personal cheque or	r account.	Institution number Accou	ınt number		
	Complete only when	statement, or contact your l					
	providing new or updated information.	By providing your email address, you will receive an email notification once your claim has been processed, including a link to <b>manulife.ca</b> , where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit <b>manulife.ca/planmember</b> to register for your Plan Member secure site.					
		Email address (Please p	rint clearly)				
10	Claims confirmation	Total amount of ALL rec	eipts \$		ORIGINAL RECEIPTS must rovided for all expenses.		
11	Authorization an	nd consent					
all reposition proto Better la an va If a cott la an the	ertify that the information goods or services as classified, together with an incremental properly through false condens, professional regional regional regional properly through false condens, professional regional gree to refund any monuthorize Manulife to dead administration, if my side as the original. Lund applicable, Lauthorize Naccount") that I have idear financial institution Inderstand and agree the professional services. Lalso undersional regional require my personal versions.	aimed. I understand and ackny related information/document ubmitted to law enforcement at laim submission. I authorize at gulatory bodies, any employer, and exchange this Information with an audit and the assessment, in providing false, incomplete or incise or overpayments that I may duct such monies from my future SIN is used as my plan member terstand that Manulife's Privacy Manulife to deposit all payments and the future at the thing of the deposit of any plan that upon the any p	ng submitted is true, accurate an owledge that submission of a cation, to my plan sponsor. I und thorities for possible prosecution by person or organization with Ingroup plan administrator, insure the each other and with Manulife envestigation and management consileading Information.  Owe to Manulife in accordance reclaims. I authorize the use of certificate number. I agree a play Policy is available at manulife. If this direct bank deposit authorize this direct bank deposit authorize that this direct bank deposit authorize that this direct bank deposit authorize many, at any time and without priguture Payment(s). I also herebor by law, shall not form part of respectives.	and complete and that I, my spous laim determined by Manulife to be erstand and acknowledge that in. Manulife will pursue the recoverage formation, including any medical rivestigative agency, and any a tis reinsurers and/or its service of this claim (Purposes). Lagree to with the provisions of the Group of my Social Insurance Number ("Particular of the Group for the Group Benefits or from my Platerned Group Benefits Plan ("Particular of the financial in the provision of the financial in the first of the first	ayments") into the bank account institution herein named by me and any		
If a is au	applicable, <u>I authorize</u> Not liable for damages verthorization. <u>I agree</u> that nderstand that if I do n	which I may incur as a result of in should the email address ident ot wish to receive emails from N	ss provided as a means of comr nterception by a third party of a ified on this form change, I am r	n email transmission sent by Mai esponsible for updating the ema	group benefits. <u>I agree</u> that Manulife nulife or by me pursuant to this ill address maintained by Manulife. contact the Customer Service Centre at		
	300-268-6195 to have n nderstand that any Info Information will be limi	ny eman andress removed		ove my email address emilie or	contact the Cacternor Corvice Contro at		

## **PLEASE SIGN HERE**

<u>I have the right</u> to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

## Signature of plan member

12 Mailing instructions

Please mail your completed claim form and receipts to:
Manulife Group Benefits
Health Claims

PO BOX 2580, STN B
MONTREAL QC H3B 5C6

Date signed (dd/mmm/yyyy) \_