

Healthcare Expenses Statement With Healthcare Spending Account

Benefits to be paid from:

- Healthcare Plan Only
 Healthcare Spending Account Only
 Both

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See PART 9.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - Plan Member Information 1					
<p>You must complete this section fully.</p> <p>If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.</p>	Plan name				
	Plan number			Plan member I.D. number	
	Plan Member Name				
	Last name			First name	
	Plan Member Address				
	Number and street				
City or town			Province	Postal code	
Date of birth:		Day	Month	Year	Language preference: <input type="checkbox"/> English <input type="checkbox"/> French

PART 2 - Coordination of benefits 2	
<p>Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.</p>	<p>1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide:</p> <p style="margin-left: 20px;">Name of insurance company</p> <p style="margin-left: 20px;">Plan number</p> <p style="margin-left: 20px;">Plan member I.D. number</p> <p>If spouse's plan, please provide spouse's date of birth:</p> <p style="margin-left: 20px;">Day Month Year</p>
	<p>2. Is treatment required as the result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is a claim being made for Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

PART 3 - Patient information 3											
<p>Complete for all expenses; one line per patient.</p>	Patient name	Relationship to plan member	Date of birth Day Month Year			If child over 18 years		Does Patient Reside with Plan Member?			
						Full time student hours per week	Yes	No	If employed, how many hours worked per week?	Yes	No
						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 4 - Prescription drug expenses 4	
<p>For all prescription drug claims</p>	<p>Attach all original receipts.</p> <ul style="list-style-type: none"> • Patient name, date of purchase, drug identification number and drug name.

PART 5 - Paramedical Expenses 5		
For chiropractor, physiotherapist, massage therapist, psychologist, etc.	Attach original receipts. Receipts must indicate the: <ul style="list-style-type: none"> Patient name, length and type of service and date of service Healthcare provider's name, address, phone number, designation and professional association Date last paid by provincial plan (if applicable) 	
	Provider's name	Type of service
		Phone number

PART 6 - Medical Expenses 6	
For medical equipment, appliances and services.	Attach original receipts and recommendation from prescribing physician, including diagnosis. Receipts must indicate the: <ul style="list-style-type: none"> Patient name, date of service and description of item purchased Provider's name, address and telephone number Provincial plan statement of payment (if applicable)

PART 7 - Visioncare Expenses 7	
Laser eye surgery, glasses, contact lenses and eye exams.	Attach original receipts. Reason for purchase of lenses? (check all that apply) <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div><input type="checkbox"/> Initial prescription</div> <div><input type="checkbox"/> Prescription change</div> <div><input type="checkbox"/> Loss or breakage</div> </div> <div style="margin-top: 5px;"><input type="checkbox"/> None of the above</div>

PART 8 - Confirmation, Authorization and Signature 8				
<p>I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.</p> <p>The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.</p> <p><i>At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.</i></p> <p><i>For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.</i></p>				
<div style="border: 1px solid black; padding: 5px; min-height: 20px;"> Plan Member signature X _____ </div>	Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 30px; height: 20px;">Day</td></tr> </table> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 30px; height: 20px;">Month</td></tr> </table> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 30px; height: 20px;">Year</td></tr> </table>	Day	Month	Year
Day				
Month				
Year				

PART 9 - Submitting Your Claim 9	
<p>Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.</p>	
<p>Questions? Call Toll Free: 1.800.957.9777</p> <p>Winnipeg Benefit Payments PO Box 3050 Station Main Winnipeg MB R3C 0E6</p> <p> For the deaf or hard of hearing: Toll Free: 1.800.990.6654</p>	