Manulife

Consumer Markets
Extended Health Care Claim

To be completed by the plan member unless otherwise indicated.
Original receipts must be attached for all expenses. (Please attach to the back of this form.)
Please retain copies for your files as original receipts will not be returned.

1 Plan member statement

Plan number	Identification number

Plan member name (first, middle initial, last)

Address (number, street and apt.)	City/Town

Province/State	Postal/Zip code	Country	Telephone number
			( )

Are these expenses eligible for coverage under any type of workers' compensation board?
◯ Yes ◯ No

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:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan number	Spouse's certificate number

2 Patient information

Complete for all expenses.
Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Amount of expense	Complete if patient is a student 18 or older: School City Province/State	Complete if patient is a student 18 or older: If employed, hrs worked per week

3 Prescription drug expenses

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the drug identification number (DIN), the name of the prescription drug, strength and quantity.
- You are not required to list this information on the form.

4 Practitioner/Paramedical expenses

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please attach an **itemized receipt** stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

Was patient referred by a physician? ◯ Yes ◯ No

Please complete next page.

5 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.

Duration equipment is required. **From** Date (dd/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has rental equipment been returned? ◯ Yes ◯ No

6 Vision care expenses

Please enclose an original itemized receipt issued by a supplier indicating:

- patient's name,
- cost of contact lenses,
- date dispensed.
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- treatment,

7 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted $ 0.00 ◯ CAD ◯ USD

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse or co-applicant and/or my dependents have received all goods or services or qualify for benefits as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented may result in coverage being rescinded by Manulife without further notice. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution and may pursue the recovery of any money obtained improperly through false claim submission. **I also agree** to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of my coverage and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** any person or organization with information concerning me, my spouse or co-applicant and/or my dependents, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its service providers, for the purposes of plan administration, audit and the assessment, investigation and management of this claim. **I agree** a photocopy; facsimile or electronic version of this authorization shall be as valid as the original.

Please sign here.

Plan member signature

Date signed (dd/mmm/yyyy)

8 Statement of confidentiality

The specific and detailed information requested on the Extended Health Care Claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, PO BOX 1602, DEL STN 500-4-A, WATERLOO, ON N2J 4C6. A copy of our privacy policy is available on **manulife.ca.**

9 Mailing instructions

Please mail your completed claim form and **original receipts** to the following address.

Manulife Consumer Markets
Health Claims
PO BOX 4214, STATION A
TORONTO ON M5W 5M4

Manulife will not assume responsibility for any fees associated with the completion of this form.

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