THE Great-West Life ASSURANCE COMPANY

Healthcare Expenses Statement

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
3. Send to the appropriate Benefit Payment Office for your plan. See PART 10.

THIS IS A: ☐ **Claim for benefits** ☐ **Pretreatment/estimate**

* Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?

Go to http://groupnet.greatwestlife.com for details.

PART 1 - Confirmation, Authorization and Signature

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.

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.

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.

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.

Plan Member signature X _____ **Date:** Day | Month | Year

PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number of plan member I.D. number, please contact your plan administrator.

Plan name

Plan number | Plan member I.D. number

Plan Member Name

First name | Last name

Plan Member Address

Number and street | City or town | Province | Postal code

Date of birth: Day | Month | Year

Language preference: ☐ English ☐ French

PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to insurance under any other plan for the expenses being claimed? ☐ Yes ☐ No

   If yes, please answer the questions below.

2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child

   First Name _____ Last Name _____

3. If the patient is a dependent child, please provide spouse's date of birth: Day | Month

4. Is the other insurance also with Great-West Life? ☐ Yes ☐ No*

   If yes, please provide: Great-West Life plan number _____ ID Number _____

5. Is treatment required as the result of an accident? ☐ Yes ☐ No

   If yes, what kind of accident? ☐ Motor Vehicle ☐ If other, please explain. _____

*If the other insurance is not with Great-West Life and you have submitted these expenses to your other insurer, please attach the other insurer Explanation of Benefits (EOB) to this claim. An EOB is required even if no benefits were paid by the other insurance.

PART 4 - Patient Information - Complete for all expenses; one line per patient.

Patient name First name/Last name	Patient's Relationship to plan member Self	Child	Spouse	Patient's Date of birth Day	Month	Year	If child over 18 years: Full time student hours per week	Yes	No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	No
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑

PART 5 - Claim Details - If additional space is needed, attach a separate page.

Patient Name - First name/Last name	Type of Expense	Nature of Illness

PART 6 - PRESCRIPTION DRUG EXPENSES - Credit card receipts and/or debit slips alone are insufficient. Official pharmacy or clinic/physician receipts are required.

All receipts must include:
- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

Please note, receipts for drugs dispensed in Ontario must include the dispense fee.

PART 7 - Paramedical Expenses - For chiropractor, physiotherapist, massage therapist, psychologist, etc.

All receipts must include:
- Patient name
- Date of service
- Name of treatment provided
- Charge for each service
- Provider's name, address, telephone number, professional designation and professional association
- Amount paid by provincial plan if applicable

PART 8 - Medical Expenses - For medical equipment, appliances and services.

All receipts must include:
- Patient name
- Date item was received
- Name of item purchased or a detailed description of the services or supplies
- Charge for each item/service
- Provider's name, address, telephone number and professional designation
- Amount paid by provincial plan if applicable

PART 9 - Visioncare Expenses - Laser eye surgery, glasses, contact lenses and eye exams.

Receipt details

All receipts must include:
- Patient name
- A breakdown of charges for lenses & frames or eye exam
- Date eyewear was received
- Date the eye exam was performed and paid for

Patient Name First name/Last name	Reason for purchase of lenses (check all that apply) Initial prescription	Prescription change	Loss or breakage	None of these reasons
	❑	❑	❑	❑
	❑	❑	❑	❑
	❑	❑	❑	❑

PART 10 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free:

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

Clear