

Healthcare Expenses Statement

Benefits will be assessed under the plan where coverage is available.

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 <input style="width: 95%;" type="text"/>				
	Plan number <input style="width: 95%;" type="text"/>		Plan member I.D. number <input style="width: 95%;" type="text"/>		
	Plan Member Name				
	Last name <input style="width: 95%;" type="text"/>		First name <input style="width: 95%;" type="text"/>		
	Plan Member Address				
	Number and street <input style="width: 95%;" type="text"/>				
City or town <input style="width: 95%;" type="text"/>			Province <input style="width: 20%;" type="text"/>	Postal code <input style="width: 20%;" type="text"/>	
Date of birth: Day <input style="width: 20%;" type="text"/>		Month <input style="width: 20%;" type="text"/>		Year <input style="width: 20%;" type="text"/>	
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 <input style="width: 80%;" type="text"/></p> <p style="margin-left: 20px;">Plan number <input style="width: 80%;" type="text"/></p> <p style="margin-left: 20px;">Plan member I.D. number <input style="width: 80%;" type="text"/></p> <p>If spouse's plan, please provide spouse's date of birth:</p> <p style="margin-left: 20px;">Day <input style="width: 20%;" type="text"/> Month <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/></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			If child over 18 years			Does Patient Reside with Plan Member?			
						hours per week	Yes	No			hours worked per week?	Yes
				Day	Month	Year		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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

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For chiropractor, physiotherapist, massage therapist, psychologist, etc.

Attach original receipts. Receipts must indicate the:

- 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

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For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis.

Receipts must indicate the:

- 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

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Laser eye surgery, glasses, contact lenses and eye exams.

Attach original receipts.

Reason for purchase of lenses? (check all that apply)

- Initial prescription
 Prescription change
 Loss or breakage
 None of the above

PART 8 - Confirmation, Authorization and Signature

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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. 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 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 certify that the information given 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 dependants.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

Plan Member signature X _____


Date: Day Month Year

PART 9 - Submitting Your Claim

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

Health SolutionsPlus Questions?
Call Toll Free: 1.877.883.7072

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