How to complete your Drug Claim Form

ASSURE CARD CLAIM FORM

The Great-West Life Assurance Company

Part 1 – EMPLOYEE INFORMATION – This section MUST be completed in full by the employee.

Employer Name: _____

Employee Name: _____

Employee Address: _____
Box No./Apt. No., Number and Street

_____ City or Town _____ Province _____ Postal Code

EMPLOYEE I.D. NO. FROM YOUR ASSURE CARD 1 1 _____

(Please DO NOT submit until all numbers can be reported)

Mail completed form to:
Great-West Life Health & Dental Benefits
P.O. Box 3050
Winnipeg MB R3C 4E5

Is this claim an adjustment to a previously paid claim? ❑ Yes ❑ No

Part 2 – CLAIMANT INFORMATION – THIS SECTION MUST LIST **ALL** CLAIMANT INFORMATION.
IMPORTANT – Original pharmacy receipts **MUST** be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee = 01; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

Part 3 – OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of School: _____

Address of School: _____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 – CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' Compensation Board or Government Plan? ❑ Yes ❑ No

If yes, please advise us of the name of the other insuring agency or plan: _____

Group Policy/Plan No.: _____ Cert./I.D. No.: _____

Spouse's day and month of birth: Day _____ Month _____

If this claim has been submitted under another plan, you **MUST** attach the original Explanation of Benefits statement from that plan and the **COPIES** of the receipts.

Part 5 – OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made? _____ Currency used _____

Nature of Illness _____ Purpose of Travelling _____

Date of Departure _____ Actual Return Date _____

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU.
PLEASE KEEP A COPY FOR YOUR RECORDS.

M6226 BIL-6/02

Complete these sections in full.

Indicate if your spouse and/or children have drug coverage under another plan.

Indicate here if your medication was purchased outside of Canada.

Mail your completed form to this address.

Attach all original receipts to your claim form.

Authorization
The **Employee** must sign and date here upon completion of this form.

Incomplete forms may be returned to you and delay processing.

Consult your plan administrator if you have any questions.