

HEALTHCARE EXPENSES STATEMENT (Medical, Vision, Drugs)

SEND THIS CLAIM TO:

The Great-West Life Assurance Company
Individual Health Unit
PO Box 6000
Winnipeg MB R3C 3A5

For inquiries call: 1-866-430-2863

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.

Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. All claims under this plan are submitted by the policyowner. We may exchange personal information about claims with the policyowner and/or a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

POLICYOWNER INFORMATION	
Policy Number <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> - <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u>	
Policyowner Name (please print) _____	
Policyowner Address _____	
Phone Number: Home _____ Work _____	

COORDINATION OF BENEFITS	
1. Are you or any other member of your family entitled to benefits from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Group <input type="checkbox"/> Individual	
If Yes, name of family member insured _____	
Name of other insurance company _____	
Policy number _____	
2. Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give date, location and explain how the accident happened. _____	
3. If patient is a dependent child, please provide spouse's date of birth. _____ / _____ / _____ Day Month Year	

DEPENDANT INFORMATION							If child over 18 years					
Patient Name	Relationship to Policyowner	Date of Birth			Does patient reside with you?		Full-Time Student?		If student, how many hours per week?	Employed?		How many hours worked per week?
		Year	Month	Day	YES	NO	YES	NO		YES	NO	
					<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"/>		<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"/>	

CLAIM DETAILS (If additional space is needed, attach a separate page)			OTHER EXPENSES		
DRUG EXPENSES					
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge

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. 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 Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator (if applicable), 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 certify the information given is true, correct and complete to the best of my knowledge.

Policyowner's Signature _____ Date _____