THE Great-West Life ASSURANCE COMPANY

CLAIM FORM

Welcome Plan

PART 1 – TO BE COMPLETED BY THE PLAN MEMBER

PLAN NUMBER ☐ 138100 ☐ 158100 ☐ 168100 ☐ 170205 ☐ 170844 ☐ 178100

LAST NAME	GIVEN NAME AND INITIAL	WELCOME PLAN ID

MAILING ADDRESS

CITY	PROVINCE	POSTAL CODE	PHONE

1. Name of Plan Sponsor (Employer) _____

   Base Plan Number _____ Base Plan Member ID _____

2. Is this claim for treatment of a dependant? ☐ Yes ☐ No

   If child 18 years or older: Full-time student? ☐ Yes ☐ No Employed? ☐ Yes ☐ No

   If yes, name of dependant _____ Birthdate of dependant _____ (Day/Month) Relationship to plan member _____

3. If claim was due to an accident, please provide location of accident _____

   Date of accident _____ How it occurred _____

4. Do you have other coverage for these expenses? ☐ Yes ☐ No

   If yes, name of other insurance company and policy number _____ Name of plan member _____

5. If yes to question 4 and patient is a dependent child, please confirm your birthdate _____ (Day/Month)

   and your spouse's birthdate _____ (Day/Month)

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 Great-West Life's chief compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare 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.

Plan Member's Signature _____ Date _____

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.

Benefits will be assigned to the provider of service unless receipts are submitted with the claim indicating that the payment has been made. The patient is financially responsible for charges not covered by this plan.

PART 2 – ATTENDING PHYSICIAN / PROVIDER'S STATEMENT

Physician Code	Date of Service			Charge	Diagnosis (complications) and Procedures – Please provide description and details of physician code(s).
	Day	Month	Year		

Date of hospital confinement: From _____ To _____

PLEASE PRINT

Physician / Provider's Name _____

Physician / Provider's Address _____

Physician / Provider's Postal Code _____ Physician / Provider's Telephone Number _____

Physician / Provider's Signature _____

(The Physician / Provider's signature, or an original receipt, is required in order to process benefits.)

PLEASE SEE OVER

TO BE COMPLETED BY PROVIDER OF SERVICE

1. LABORATORY Name of Facility _____

Address of Facility _____

Facility's Postal Code _____ Facility's Telephone No. _____

Referring Physician's Name _____

DATE OF SERVICE	PHYSICIAN CODE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES

2. RADIOLOGY Name of Facility _____

Address of Facility _____

Facility's Postal Code _____ Facility's Telephone No. _____

Referring Physician's Name _____

DATE OF SERVICE	PHYSICIAN CODE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES

3. OTHER EXPENSES

DATE OF SERVICE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES

Physician / Provider's Signature _____

Forward completed claim form and original receipts to:

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

Telephone: 1.866.430.2863

Clear