THE Great-West Life ASSURANCE COMPANY

Health SolutionsPlus HEALTHY LIVING ACCOUNT

INSTRUCTIONS

1. **Complete part 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 3.**

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member or a person acting on their behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1: PLAN MEMBER'S STATEMENT

Plan Member Name _____ Date of Birth _____

Plan Member Home Mailing Address _____
STREET CITY/TOWN PROVINCE POSTAL CODE

Group or Plan Name _____ Plan Number _____ ID Number _____

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 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 I am claiming expenses that were incurred by myself or an eligible dependent.

Employee's Signature _____ Date _____

PART 2: CLAIM INFORMATION

Include receipts with your claim for reimbursement. Please indicate (✔) the expense and amount you are claiming.

Type of Eligible Expenses:

- ☐ $ _____ Certified Instruction (e.g. personal trainer) or instructed classes at a fitness facility (e.g. aerobics / pilates / cycle / dance)
- ☐ $ _____ Exercise equipment (new or used), repairs and extended warranty
- ☐ $ _____ Weight Management programs (food excluded)
- ☐ $ _____ Vitamins / Minerals / Supplements / Natural Health Products / Herbal remedies
- ☐ $ _____ Alternative healing therapies (e.g. Reiki / Shiatsu Therapists)
- ☐ $ _____ Health / Stress Management programs (e.g. spa / wellness retreats)
- ☐ $ _____ Smoking Cessation programs and products
- ☐ $ _____ Fitness Centre membership fees (Drop in / Monthly / Annual Fee)
- ☐ $ _____ Athletic Facility fees, including Sports and Golf / Country Club fees (receipt must include the name of facility or league)
- ☐ $ _____ Other: Please describe _____

Total receipts included _____ **Total Claim** **$** 0.00

HEALTH SOLUTIONSPLUS - HEALTHY LIVING ACCOUNT EXPENSES ARE REIMBURSED AT 100% OF ELIGIBLE EXPENSES, SUBJECT TO AVAILABLE CREDITS. ALL REIMBURSED CLAIMS WILL BE TREATED AS A TAXABLE BENEFIT.

PART 3: SUBMITTING YOUR CLAIM

Please send your claim to the Benefits 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

M7311-8/18

Clear