THE Great-West Life ASSURANCE COMPANY

Pre-treatment / Estimate for Continuous Glucose Monitor (CGM)

To be submitted with initial CGM estimates only

Charges for completing this form or providing medical information are not covered by your plan.

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Plan member to complete parts 1 through 5, Physician to complete part 6
3. Attach estimate and retain copies for your files as originals will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See Part 7.

PART 1 - Confirmation, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services related to this form that may be claimed will be received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

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. 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.

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.

Plan Member signature X _____

Day	Month	Year

PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name

Plan number | **Plan member I.D. number**

Plan Member Name

First name | **Last name**

Plan Member Address

Number and street | **City or town** | **Province** | **Postal code**

Date of birth:

Day	Month	Year

Language preference:

☐ English ☐ French

PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No

   If yes, please answer the questions below.

2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child

   Last Name _____ First Name _____

3. If the patient is a dependent child, please provide spouse's date of birth:

Day	Month	Year

4. Is the other insurance also with Great-West Life? ☐ Yes ☐ No

   If yes, please provide: Great-West Life plan number _____ ID Number _____

5. Is treatment required as the result of an accident? ☐ Yes ☐ No

   If yes, what kind of accident? ☐ Motor Vehicle ☐ If other, please explain. _____

   _____

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PART 4 - Patient Information

Patient name First name/Last name	Patient's Relationship to plan member Self	Child	Spouse	Patient's Date of birth Day	Month	Year	If child over 18 years: Full time student hours per week	Yes	No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	No
	☐	☐	☐					☐	☐		☐	☐

PART 5 – Estimate Expenses – Please attach a copy of your estimate

Type of Expense	Estimated Charges

Please have Part 6 completed by your prescribing Physician. This is required with your initial Continuous Glucose Monitor and/or associated supplies only.

PART 6 - Confirmation of eligibility for a Continuous Glucose Monitor and/or associated supplies (To be completed by Physician)

1. Are you prescribing a Continuous Glucose Monitor and/or supplies for the patient? ☐ Yes ☐ No
2. Please confirm the patient's medical diagnosis ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Other _____
3. Does the patient use insulin to manage their glucose? ☐ Yes ☐ No

Physician's Name and Address _____

Registration Number _____

Physician's Signature _____ **Date:** Day | Month | Year

PART 7 - Submitting Your Form

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

Questions? Call Toll Free: 1.800.957.9777

Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

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

Clear