THE Great-West Life ASSURANCE COMPANY

WELLNESS/LIFESTYLE ACCOUNT EXPENSES STATEMENT

INSTRUCTIONS:

1. Complete this form in full. Sign and date the form.
2. Please attach original receipts along with 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 4.

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 being claimed have been 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

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PART 3 - Claim Details

Original receipts must be included with your claim. Please indicate the expense and amount you are claiming.

Miscellaneous Expenses: Please describe

☐ $ _____
☐ $ _____
☐ $ _____
☐ $ _____
☐ $ _____

Total original receipts included _____ Total Claim $ 0

Eligible expenses vary according to the coverage available under your group benefit plan. To find out whether an expense is eligible for coverage under your group benefit plan, please refer to your plan booklet. All reimbursed claims will be treated as a taxable benefit.

PART 4 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below.

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

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