THE Great-West Life ASSURANCE COMPANY

HEALTHCARE

HEALTHCARE SPENDING ACCOUNT PLAN (SIDE 1)

IMPORTANT: Payment may be delayed if this form is not fully completed.
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.

Please print

PART 1: EMPLOYEE'S STATEMENT

Employee Name _____ Date of Birth _____

Employee Home Mailing Address _____
STREET CITY/TOWN PROVINCE POSTAL CODE

Group or Plan Name _____ Plan Number _____ ID Number _____ Div.# _____

1. Are any of your eligible dependents insured as an employee under this plan? ☐ Yes ☐ No

   If yes, name of eligible dependent _____ I.D. Number _____

2. Are you or any of your eligible dependents entitled to medical benefits under any other plan? ☐ Yes ☐ No

   If yes, name of eligible dependent insured _____ Relationship to employee _____

   Name of other insurance Company _____ Policy Number _____

3. If yes to question 1 or 2 above, and the patient is a dependent child, give: Employee's birthdate (Day/Mo.) _____

   Spouse's birthdate (Day/Mo.) _____

4. If patient is other than employee's spouse or child under 21, is employee entitled to claim a medical expense tax credit under the Income Tax Act (Canada) in respect of the patient? ☐ Yes ☐ No

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 a person(s) for whom I am entitled to claim a medical expense credit under the *Income Tax Act* (Canada).

I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

PART 2: DEPENDENT INFORMATION

(To be completed if claim includes any expense for a dependent.)

Patient Name	Relationship to Employee	Date of Birth Year Month Day	Does patient reside with you?	If child over 18 years: Full-Time Student?	If student, how many hours per week at school?	Employed?	If yes, how many hours worked per week?
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

PART 3: CLAIM INFORMATION

NOTE: *Please attach a receipt or bill for each item claimed. Receipts and bills, other than those required for government drug plans, are part of our records and will not be returned. The Explanation of Benefits that will accompany our cheque should be kept for your records and for Income Tax purposes.*

A. DRUG CHARGES

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE.

Name of Patient	For each Patient Show Only Date of First and Last Receipt		No. of Receipts	Total Charge
	From	To		$
	From	To		$
	From	To		$
	From	To		$
	From	To		$

Please ask your pharmacist to indicate Prescription Number, Drug Identification Number (DIN) and brand name on each drug receipt submitted.

TURN OVER FOR SIDE 2

B. OTHER EXPENSES (ambulance, chiropractor & visioncare, etc.)

Name of Patient	Provider of Service	Type of Service	Date of Service	Charge	Nature of Illness

Clear

SEND THIS CLAIM TO:

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

HEALTHCARE CLAIM FORM
COMPLETION CHECK LIST

1) HAS THE EMPLOYEE SIGNED THE CLAIM FORM – SIDE 1?

2) HAS ALL OF THE PATIENT/DEPENDENT INFORMATION BEEN COMPLETED – SIDE 1 AND 2?

3) HAS ALL THE NECESSARY CLAIM FORM DOCUMENTATION BEEN ATTACHED TO THIS CLAIM FORM? SUCH AS:

- GREAT-WEST LIFE OR OTHER INSURER'S EXPLANATION OF BENEFITS, (WHERE INSURER HAS ALREADY PROCESSED OR PAID SOME PORTION OF THE CLAIM),
- PROVINCIAL HEALTH PLAN STATEMENT,
- RECEIPTS,
- PRESCRIPTIONS.