

 PLEASE SEE REVERSE FOR DETAILS ON HOW TO SUBMIT YOUR CLAIM.
IS THE CLAIM FOR DRUG EXPENSES ONLY? YES NO

PART 1 EMPLOYEE STATEMENT It is suggested that any treatment exceeding \$500 should be approved by the insurer before it begins.

Group Contract Number 335663	Certificate Number	
Employer _____		
Employee Last Name _____	First Name _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Employee's Address (Street, City, Province, Postal Code) _____		Employee's Date of Birth Day _____ Month _____ Year _____

PART 2 CHARGES Please indicate total charges separately for each patient (one line per person).

Patient's Name	Relationship to Employee	Date of Birth			Type of Expense ie. Drugs, Podiatrist	Date Expenses Incurred from and to						Total Paid Receipts	
		Day	Month	Year		Day	Month	Year	Day	Month	Year		

RECEIPTS PAID IN FULL

PART 3 CO-ORDINATION OF BENEFITS

1. If the patient is a child, does the patient reside with you? Yes No

2. If the child is over 18: a) Is he/she a full-time student? Yes No

b) If student, how many hours per week at school? _____

c) Is he/she employed? Yes No If yes, how many hours worked per week? _____

d) Is he/she mentally or physically challenged Yes No

3. a) Is any member of your family (other than yourself) insured as an employee under this plan? Yes No

b) Are you or any other member of your family entitled to benefits under any other plan? Yes No

If yes, name of family member insured _____ Relationship to employee _____

Name of other insurance company _____ Policy number _____

c) If yes to questions 3 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth _____ / _____ / _____
Day Month Year

4. Is this treatment required as the result of an accident? Yes No If yes, give date, location, and explain how accident happened:

5. Is a claim being made for Worker's Compensation Benefits? Yes No

AUTHORIZATION

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 provider, my plan administrator, other insurance or re-insurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

CLAIMING HEALTH INSURANCE BENEFITS



When submitting out-of-country/province claims, please refer to your TravelAssist Brochure/booklet for claiming procedures.

Attach original paid accounts/receipts to the back of the claim form. Photocopies (unless submitting for co-ordination of benefits), carbon copies, credit card receipts or cash register receipts are not acceptable. Please retain copies of receipts for your files, as originals will not be returned.

For drug claims, the prescription number and name of drug or D.I.N. (Drug Identification Number) must be shown on all receipts. The services of a psychologist, physiotherapist, speech therapist, massage therapist, or occupational therapist must be prescribed by a physician in order to be considered an eligible charge. Please attach to the back of the claim form, your original referral for service from your Doctor along with your original paid accounts/receipts.

The initial charges for medical services and supplies including crutches, splints, canes and braces, must be prescribed by a physician in order to be an eligible charge. Please attach to the back of the claim form, your original paid accounts/receipts along with your original prescription and an original Doctor's report which includes: the date of accident/injury, diagnosis, when the appliance/apparatus is to be worn, and a description of the appliance/apparatus.

Under the co-ordination of benefits provision, if your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan. Charges for dependent children should first be submitted to the plan of the parent whose month and day of birth comes first in the calendar year.

REMINDER

It is suggested that you accumulate at least \$50.00 in total expenses before submitting a claim.

Proof of claim must be submitted within 120 days following the earlier of your termination of employment or the end of the calendar year in which the expense is incurred. Claims submitted after the deadline will not be considered for payment.

This form must be completed in full. Incomplete forms will be returned to you, which will delay the processing of the claim.

MAIL THE COMPLETED FORM DIRECTLY TO THE CLAIMS OFFICE INDICATED BELOW

Regina Benefit Payments
P.O. Box 4408
Regina SK S4P 3W7
Toll Free: 1-866-408-0213



For the deaf or hard of hearing:
Toll Free: 1-800-990-6654
Or: (204) 946-7281