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CLAIM FORM
EXTENDED HEALTH CARE/PRESCRIPTION DRUG PLAN (51391)
VISION & HEARING CARE PLAN (51392)

THE Great-West Life ASSURANCE COMPANY

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.
All claims under this group benefits plan are submitted through the employee. We may exchange personal information about claims with the employee and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

EMPLOYEE'S STATEMENT

Last Name	First Name	Date of Birth (Year / Month / Day)	Employee ID No.

Address	City	Province	Postal Code

Phone Number
HOME: ( ) WORK: ( )

Language Preference ☐ English ☐ French

COORDINATION OF BENEFITS:

- Are you or any other member of your family entitled to benefits under any **other** health care plan? ☐ Yes ☐ No
  If "Yes", name of family member insured _____
  Relationship to employee _____ Spouse's date of birth ____ /____ Month Day
  Name of other insurance company _____
  Policy Number _____ I.D. Number _____
- Is any member of your family (other than yourself) entitled to benefits as an employee under the Vision and Hearing Care Plan (51392)? ☐ Yes ☐ No
  I.D. Number _____
- Is treatment required as the result of an accident? ☐ Yes ☐ No
  If "Yes", give date, location and explain how accident happened
  _____
- Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

INSTRUCTIONS

Fast track your health claims with GroupNet for Plan Members. Get reimbursed in as little as one day.
Register on groupnet.greatwestlife.com and sign up for direct deposit.

Send form to Great-West Life:

QUEBEC RESIDENTS, OTHER THAN NATIONAL CAPITAL REGION RESIDENTS:

Montreal Benefit Payments
Place Bonaventure
800 de la Gauchetière Street W Suite 5800
Montréal QC H5A 1B9

FOR ALL OTHER RESIDENTS:

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

1.866.716.1313
TTY line - available for the deaf or hard of hearing
Toll Free: 1.800.990.6654

DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth (Year / Mth / Day)	If child is 21 years of age or older: Full-Time Student? (YES / NO)	With a Disability? (YES / NO)
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐

CLAIM DETAILS

Patient Name	Type of Expense	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

PLEASE KEEP A COPY OF THIS FORM, RECEIPTS AND ANY OTHER RELEVANT DOCUMENTATION FOR YOUR RECORDS

EMPLOYEE'S 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. 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 the information given is true, correct, and complete to the best of my knowledge**.

Employee's Signature _____ Date _____

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