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Claim Form
Extended Health Care Plan (162954)
Healthcare Spending Account

Benefits to be paid from:
- ☐ Healthcare Plan Only
- ☐ Healthcare Spending Account Only
- ☐ Both

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date 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 10.

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 their behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - 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 Member Name

First name | Last name

Plan member I.D. number

Plan Member Address

Number and street

City or town | Province | Postal code

Date of birth: Day | Month | Year

Language preference: ☐ English ☐ French

PART 2 - 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 provide:**

Name of insurance company

Plan number

Plan member I.D. number

If spouse's plan, please provide spouse's date of birth:

Day | Month | Year

2. **Is treatment required as the result of a motor vehicle accident?** ☐ Yes ☐ No

3. **Is a claim being made for Workers' Compensation Benefits?** ☐ Yes ☐ No

PART 3 - Healthcare Spending Account (HCSA)

Are you submitting a claim for premiums paid under this plan? ☐ Yes ☐ No

If "Yes", amount $

PART 4 - Patient information

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth			If child 21 years or older				Is patient unmarried and financially dependent?	
					Full time student		With a disability?			
		Day	Month	Year	Yes	No	Yes	No	Yes	No
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

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Canada Life
Healthcare Expenses Statement

PART 5 - Prescription drug expenses

For all prescription drug claims

Attach all original receipts.
- Patient name, date of purchase, drug identification number and drug name.

PART 6 - Paramedical Expenses

For chiropractor, physiotherapist, massage therapist, psychologist, etc.

Attach original receipts. Receipts must indicate the:
- Patient name, length and type of service and date of service
- Healthcare provider's name, address, phone number, designation and professional association
- Date last paid by provincial plan (if applicable)

Provider's name	Type of service	Phone number

PART 7 - Medical Expenses

For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis.
Receipts must indicate the:
- Patient name, date of service and description of item purchased
- Provider's name, address and telephone number
- Provincial plan statement of payment (if applicable)

PART 8 - Visioncare Expenses

Laser eye surgery, glasses, contact lenses and eye exams.

Attach original receipts.
Reason for purchase of lenses? (check all that apply)

☐ Initial prescription ☐ Prescription change ☐ Loss or breakage
☐ None of the above

PART 9 - 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 dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

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).

The submission of fraudulent claims is a criminal offence. Canada 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 Canada 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 Canada 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 Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member signature X _____

Date: Day | Month | Year

PART 10 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below.

Questions? Call Toll Free: 1.866.716.1313

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

www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

Clear