



PLAN #154850

HEALTHCARE EXPENSES STATEMENT



INSTRUCTIONS FOR THE USE OF THIS FORM - SEE ADDITIONAL KEY INSTRUCTIONS ON REVERSE

- 1. Employee's statement must be completed and signed by the employee, or else it will be returned to the employee.
2. Submit only original receipts and retain copies for your records; photocopies are not acceptable.
3. Receipts will not be returned. Your explanation of benefits statement is sufficient for income tax purposes.
4. Group your receipts by family members, into drug and non-drug expenses and in date order.
5. All claims must be submitted within 15 months of the expense being incurred. Claims submitted after this limit are not covered under the terms of your plan.

EMPLOYEE'S STATEMENT (COMPLETE IN FULL TO AVOID DELAY OF PAYMENT)

Employee's Name (please print) Last First Initial I.D. Number Male Female Date of Birth Day Month Year
Address Street Apartment Number
City Province Postal Code

Is this claim for services required as the result of an accident? Yes No Day Month Year

If yes, how did it happen? Date of accident

Where did it happen? at home at work elsewhere

If dental accident, we require X-rays taken after the accident and prior to treatment (if any)

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR A DEPENDENT

Table with columns: First name plus Last name, Relationship to employee (Spouse, Son, Daughter, Other), Date of Birth (Day, Month, Year), If dep. child is 21 and over (Student, Handicapped), Total \$ Claimed

If expenses are for "other", please indicate their relationship to the employee.

If the patient is a child over 21: a) is he/she a full-time student? Yes No If yes, name of school
b) Is he/she employed? Yes No If yes, how many hours worked per week?

COORDINATION OF BENEFITS

- 1. Is any other member of your family insured as an employee under this plan? Yes No
If yes, name of family member
2. Are you or any other member of your family entitled to medical benefits under any other plan? Yes No
If yes, name of family member 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.) AND
Spouse's birthdate (Day/Mo.)

TOTAL AMOUNT CLAIMED \$

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Date Employee's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

## Additional Key Instructions

It is clear that the financial health and success of a group medical plan is dependent upon the concern and cooperation of employee, employer and administrator. The following is not only a means to assure Great-West Life's prompt and due claim adjudication service, but it is also an information vehicle assisting you, the consumer, to actively contribute to the group medical plan's course of progress.

The bottom line: In order to help us keep the cost of your plan at the lowest possible level, please review the following with care:

1. There are many generic drugs on the market which are considerably less expensive than brand name drugs you may have become accustomed to purchasing. We suggest you make enquiries about these with your pharmacist or doctor and when suitable purchase the least expensive.
2. Cost of drugs may vary significantly between pharmacies; we would suggest you do comparative shopping.
3. The receipts you submit must include the name of the patient, the nature of the treatment or medical supply, the name of the prescribing physician, the date furnished or the date medication was purchased and the amount charged.

### MAIL THE COMPLETED FORM DIRECTLY TO GREAT-WEST LIFE AT THE ADDRESS BELOW:

Great-West Life Health & Dental Benefits  
Place Bonaventure  
Suite 5800  
800 de la Gauchetière St. W  
Montreal QC H5A 1B9  
1-800-663-2817  
(514) 878-1288

Great-West Life will send a cheque and explanation of benefits directly to you at the address you indicate on the reverse of this form. Please ensure that you provide your full mailing address.

**IMPORTANT:** All claims must be submitted within 15 months of the expense being incurred. Claims submitted after this limit are not covered under the terms of your plan.