THE Great-West Life ASSURANCE COMPANY

Healthcare Expenses Statement
With 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 9.

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.

PART 1 - Plan Member Information (1)

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 name

Plan number | Plan member I.D. number

Plan Member Name

Last name | First name

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 (2)

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 - Patient information (3)

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 18 years: Full time student hours per week	Full time student Yes	Full time student No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	Does Patient Reside with Plan Member? No
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑
				❑	❑		❑	❑

PART 4 - Prescription drug expenses (4)

For all prescription drug claims

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

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PART5-ParamedicalExpenses 5

Forchiropractor, physiotherapist, massage therapist, psychologist,etc.

Attachoriginalreceipts.Receiptsmustindicatethe:
- **Patientname,lengthandtypeofserviceanddateofservice**
- **Healthcareprovider'sname,address,phonenumber,designationandprofessionalassociation**
- **Datelastpaidbyprovincialplan(ifapplicable)**

Provider'sname	Typeofservice	Phonenumber

PART6-Medical Expenses 6

Formedical equipment, appliancesand services.

Attachoriginalreceiptsandrecommendationfromprescribingphysician,includingdiagnosis.
Receiptsmustindicatethe:
- **Patientname,dateofserviceanddescriptionofitempurchased**
- **Provider'sname,addressandtelephonenumber**
- **Provincialplanstatementofpayment(ifapplicable)**

PART7-VisioncareExpenses 7

Lasereye surgery,glasses, contact lenses andeyeexams.

Attach original receipts.
Reasonforpurchaseoflenses?(checkallthatapply)

❑ **Initial prescription** ❑ **Prescriptionchange** ❑ **Lossorbreakage**
❑ **Noneoftheabove**

PART8-Confirmation,AuthorizationandSignature 8

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.

Iauthorize Great-WestLife,anyhealthcareordentalcareprovider, myplanadministrator,otherinsuranceorreinsurancecompanies, administratorsofgovernmentbenefitsorotherbenefits programs,otherorganizationsorserviceprovidersworkingwith Great-WestLife,locatedwithinoroutsideCanada,toexchange personalinformationwhennecessaryforthesepurposes.

Iunderstandthatpersonalinformationmaybesubjectto disclosuretothoseauthorizedunderapplicablelawwithinor outsideCanada.

Icertifythattheinformationgivenistrue,correctandcomplete tothebestofmyknowledge.

Icertifythatallgoodsandservicesbeingclaimedhavebeen receivedbyme,myspouseand/ormydependants.

IcertifythatIamclaimingexpensesthatwereincurredby myselforaperson(s)forwhomIamentitledtoclaimamedical expensecreditundertheIncomeTaxAct(Canada).

PlanMembersignatureX _____ **Date:** Day | Month | Year

PART9-SubmittingYourClaim 9

PleasesendyourclaimtotheBenefitPaymentOfficebelow.Ifblank,pleaseconsultyourplanadministratorfortheaddress.

Questions?CallTollFree: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