THE **Great-West Life** ASSURANCE COMPANY

# HEALTHCARE EXPENSES STATEMENT

**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.

*Please print*

## PART 1: EMPLOYEE'S STATEMENT

| PLAN NUMBER | DIVISION NO. | PLAN NAME |
|---|---|---|
| | | |

| EMPLOYEE IDENTIFICATION NUMBER | EMPLOYEE NAME | DATE OF BIRTH Year Month Day |
|---|---|---|
| | | |

| ADDRESS: NUMBER AND STREET | TOWN | PROVINCE | POSTAL CODE | PHONE # HOME: WORK: |
|---|---|---|---|---|
| | | | | |

## COORDINATION OF BENEFITS:

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 _____

Is any member of your family (other than yourself) insured as an employee under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth _____ / _____ (Day / Month)

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

## DEPENDENT INFORMATION

| Patient Name | Relationship to Employee | Date of Birth Year | Mth | Day | Does patient reside with you? YES NO | Full-Time Student? YES NO | If child over 18 years: If Student, how many hours per week? | Employed? YES NO | How many hours worked per week? |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ☐ ☐ | ☐ ☐ | | ☐ ☐ | |
| | | | | | ☐ ☐ | ☐ ☐ | | ☐ ☐ | |
| | | | | | ☐ ☐ | ☐ ☐ | | ☐ ☐ | |
| | | | | | ☐ ☐ | ☐ ☐ | | ☐ ☐ | |
| | | | | | ☐ ☐ | ☐ ☐ | | ☐ ☐ | |

## CLAIM DETAILS

| DRUG EXPENSES | | OTHER EXPENSES | | |
|---|---|---|---|---|
| Patient Name | Number of Receipts | Total Charge | Type of Expense | Nature of Illness | Total Charge |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

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 the use of my Social Insurance Number as an identification number where it is required in the administration of my 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.

SIGNATURE OF EMPLOYEE _____ DATE _____



CLEAR