THE **Great-West Life** ASSURANCE COMPANY

SELECTPAC

HEALTHCARE/VISIONCARE 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	PLAN NAME

EMPLOYEE I.D. NUMBER	EMPLOYEE NAME	DATE OF BIRTH Year Month Day

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

COORDINATION OF BENEFITS:

Does your spouse work for same employer? ☐ Yes ☐ No

If so, indicate his/her name: _____

Identification No. _____

Are you or your dependent entitled to benefits under any other group insurance plan?

☐ Yes ☐ No

If so, name of other group insurer: _____

Policy No. _____

Name of family member insured: _____

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

If patient is a dependent child, please provide spouse's date of birth. Year Month Day

SEND THIS CLAIM TO:

Great-West Life Health & Dental Benefits
255 Dufferin Avenue
London ON N6A 4K1
1-800-263-5742
(519) 435-6903

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?
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					☐ ☐	☐ ☐		☐ ☐	
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CLAIM DETAILS

	DRUG EXPENSES		MEDICAL/VISIONCARE 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