

## 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. 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.

**Please print**

| EMPLOYEE INFORMATION   |  |              |  |               |  |          |  |  |  |
|--|--|--------------|--|---------------|--|----------|--|--|--|
| PLAN NUMBER  |  | DIVISION NO. |  | PLAN NAME     |  |          |  |  |  |
| EMPLOYEE IDENTIFICATION NUMBER   |  |              |  | EMPLOYEE NAME |  |          |  | DATE OF BIRTH  |  |
| <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> |  |              |  |               |  |          |  | <div> <div>Year</div> <div>Month</div> <div>Day</div> </div> |  |
| ADDRESS: NUMBER AND STREET   |  |              |  | TOWN          |  | PROVINCE |  | POSTAL CODE  |  |
|  |  |              |  |               |  |          |  | PHONE #  |  |
|  |  |              |  |               |  |          |  | HOME: WORK:  |  |

|   |   |
|---|---|
| <p><b>COORDINATION OF BENEFITS</b></p> <p>Are you or any other member of your family entitled to benefits under any other plan?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If "Yes", name of family member insured _____</p> <p>Relationship to employee _____</p> <p>Name of other insurance company _____</p> <p>Policy Number _____</p> <p>Is any member of your family (other than yourself) insured as an employee under this plan?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth _____ / _____</p> <p style="text-align: center;">Day                      Month</p> <p>Is treatment required as the result of an accident?   <input type="checkbox"/> Yes   <input type="checkbox"/> No    If "Yes", give date, location and explain how accident happened _____</p> <p>Is a claim being made for Worker's Compensation Benefits?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> | <p><b>SEND THIS CLAIM TO:</b></p> <p><b>Regina Benefit Payments</b><br/> <b>P.O. Box 4408</b><br/> <b>Regina SK S4P 3W7</b><br/> <b>English: 1-866-289-5675</b><br/> <b>French: 1-866-814-6503</b><br/> <b>TTY line - available for the deaf or hard of hearing</b><br/> <b>Toll Free: 1-800-990-6654   Phone: (204) 946-7281</b></p> |
|---|---|

| DEPENDENT INFORMATION |                          |               |     |     |                               | If child over 18 years   |                          |                          |                                      |                          |                          |                                 |
|-----------------------|--------------------------|---------------|-----|-----|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|---------------------------------|
| Patient Name          | Relationship to Employee | Date of Birth |     |     | Does patient reside with you? |                          | Full-Time Student?       |                          | If Student, how many hours per week? | Employed?                |                          | How many hours worked per week? |
|                       |                          | Year          | Mth | Day | YES                           | NO                       | YES                      | NO                       |                                      | YES                      | NO                       |                                 |
|                       |                          |               |     |     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                 |
|                       |                          |               |     |     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                 |
|                       |                          |               |     |     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                 |
|                       |                          |               |     |     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                 |
|                       |                          |               |     |     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                 |

[illegible]

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

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. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE

DATE \_\_\_\_\_