THE Great-West Life ASSURANCE COMPANY

Public Sector Group Insurance Plan

Claim for Group Health Benefits

PLEASE SEE REVERSE FOR DETAILS ON HOW TO SUBMIT YOUR CLAIM.
IS THIS CLAIM FOR DRUG EXPENSES ONLY? ☐ **YES** ☐ **NO**

EMPLOYEE STATEMENT

Please print

Group Contract Number	Certificate Number	Account/Division Number	Employee Class	Location Code
56530				

Employer | Employer's Address

Employee Surname | Given Name

Employee's Address (Street, City, Province, Postal Code) | Employee's Date of Birth Day Month Year

DO YOU WANT ANY UNPAID PORTION OF YOUR CLAIM PROCESSED THROUGH YOUR HEALTH SPENDING ACCOUNT? (if applicable)

☐ Yes ☐ No

CHARGES

Please indicate total charges separately for each patient (one line per person).

Full Name	Relationship to Employee	Date of Birth Day	Month	Year	Type of Expense ie. Drugs, Podiatrist	Date Expenses Incurred Day	Month	Year	Day	Month	Year	Total Paid Receipts
										RECEIPTS PAID IN FULL		

QUESTIONNAIRE

Is this claim on yourself or your dependents for a **Work Related** Accident or Sickness? ☐ Yes ☐ No

Is this claim for a dependent? ☐ Yes ☐ No
Is this dependent employed? ☐ Full-time ☐ Part-time
If Yes, indicate the name and address of dependent's employer

Does the claimant have any other Group Health Coverage? ☐ Yes ☐ No
If Yes, indicate the name of the employer and the Insurance Company

Does the claimant have any other Group Dental Coverage? ☐ Yes ☐ No
If Yes, indicate the name of the employer and the Insurance Company

Is the claim for a dependent? ☐ Yes ☐ No
If Yes, indicate the name of your spouse | Spouse's Date of birth Day Month

If claim is for a child between the ages of 19 through 22 (based on policy), or over, indicate ☐ Handicapped ☐ Student
If student, indicate the name of School or University | Student ID #

AUTHORIZATION

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.

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, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Date (day, month, year) | Signature of Employee

Clear

THE
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CLAIMING HEALTH INSURANCE BENEFITS

When submitting out-of-country/province claims, please refer to your Travel Assistance card/booklet for claiming procedures.

Attach **original** paid accounts/receipts to back of form. **Photostats** (unless submitting for co-ordination of benefits), **carbon copies, credit card receipts or cash register receipts** are not acceptable.

Please retain copies of receipts for your files, as originals will not be returned.

For drug claims, prescription number and name of drug or D.I.N. (Drug Identification Number) must be shown on all receipts.

Charges for dependent children should be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year (excluding the year of birth).

REMINDER

It is suggested that you accumulate at least $50.00 in total expenses before submitting a claim.
Please refer to your employee booklet to confirm the amount of time you have to submit a claim.
This form must be completed in full. Incomplete forms will be returned to you, which will delay the processing of the claim.

DISCLOSURE

Great-West Life is committed to protecting the confidentiality of your personal information and will establish comprehensive safeguards to protect that confidentiality. Such safeguards include internal restrictions of access to your personal information by only individuals working for or on behalf of Great-West Life who have a need to know the information.

Any personal information you provide to us will be kept in a file established in our Group Life and Health Benefits Department and will only be used for the purpose outlined in your file and for which you have given your permission except where required by law, to protect the interest of Great-West Life or in the discharge of our public duty.

GREAT-WEST LIFE CLAIMS OFFICES

Please submit to:

Questions? Call Toll Free: 1.800.957.9777

Prince Edward Island Benefit Payments
47C Beach Grove Road
Charlottetown PE C1E 1K5

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654