THE Great-West Life ASSURANCE COMPANY

Extended Health Care Claim

3S Health

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

PART 1 EMPLOYEE STATEMENT

It is suggested that any treatment exceeding $500 should be approved by the insurer before it begins.

Group Contract Number: 335663
Benefit ID

Employer

Employee Last Name | First Name | Gender ☐ Female ☐ Male

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

PART 2 CHARGES

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

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

PART 3 CO-ORDINATION OF BENEFITS

1. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
2. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? ____________
   c) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? ____________
   d) Is he/she mentally or physically challenged ☐ Yes ☐ No
3. a) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   b) 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 ____________
   c) If yes to questions 3 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/____/____ Day Month Year
4. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location, and explain how accident happened:
   ____
5. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

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.

Employee's Signature ____________ Date ____________

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CLAIMING HEALTH INSURANCE BENEFITS

When submitting out-of-country/province claims, please refer to your TravelAssist Brochure/booklet for claiming procedures.

Attach original paid accounts/receipts to the back of the claim form. Photocopies (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, the prescription number and name of drug or D.I.N. (Drug Identification Number) must be shown on all receipts. The services of a psychologist, physiotherapist, speech therapist, massage therapist, or occupational therapist must be prescribed by a physician in order to be considered an eligible charge. Please attach to the back of the claim form, your original referral for service from your Doctor along with your original paid accounts/receipts.

The initial charges for medical services and supplies including crutches, splints, canes and braces, must be prescribed by a physician in order to be an eligible charge. Please attach to the back of the claim form, your original paid accounts/receipts along with your original prescription and an original Doctor's report which includes: the date of accident/injury, diagnosis, when the appliance/apparatus is to be worn, and a description of the appliance/apparatus.

Under the co-ordination of benefits provision, if your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan. Charges for dependent children should first be submitted to the plan of the parent whose month and day of birth comes first in the calendar year.

REMINDER

It is suggested that you accumulate at least $50.00 in total expenses before submitting a claim.

Proof of claim must be submitted within 120 days following the earlier of your termination of employment or the end of the calendar year in which the expense is incurred. Claims submitted after the deadline will not be considered for payment.

This form must be completed in full. Incomplete forms will be returned to you, which will delay the processing of the claim.

MAIL THE COMPLETED FORM DIRECTLY TO THE CLAIMS OFFICE INDICATED BELOW

Questions? Call Toll Free: 1.866.408.0213

Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7

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