THE Great-West Life ASSURANCE COMPANY

OUT-OF-SCOPE MEMBERS
HEALTHCARE EXPENSES
HEALTHCARE SPENDING ACCOUNT CLAIM FORM

3s Health

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.
Lifestyles Spending Account expenses must be submitted to 3sHealth.
Please print

SEND THIS CLAIM TO:

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

PART 1 PLAN MEMBER INFORMATION

PLAN NUMBER	PLAN NAME
335663	HEALTH SHARED SERVICES SASKATCHEWAN (3sHEALTH)
BENEFIT ID	PLAN MEMBER NAME — DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET	TOWN — PROVINCE — POSTAL CODE

PART 2 COORDINATION OF BENEFITS

Benefit payments from the HSA should be coordinated with the benefits provided by your other extended health care plan to provide up to a maximum of 100% of coverage. To maximize the benefits of your HSA, submit expenses first to your extended health care plan, and if you have additional extended health care plan coverage through a spouse's plan, submit your expenses to that plan next. Then submit your expenses to your HSA for reimbursement. Remember, you can use the HSA account to cover expenses for you and your eligible dependents.

1. **Benefits are to be paid from:** ☐ **Extended Health Care Plan** ☐ **HCSA** ☐ **Both**
2. If claiming for reimbursement from the HCSA Account, are you entitled to claim a medical expense tax credit under the income Tax Act (Canada) for the patient? ☐ Yes ☐ No

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 Plan Member _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than yourself) insured as a plan member under this plan? ☐ Yes ☐ No

If yes, name of family member _____

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

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

PART 3 DEPENDENT INFORMATION

Patient Name	Relationship to Plan Member	Date of Birth (Year / Month / 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?	If child over 18 years: Employed? YES NO	If child over 18 years: How many hours worked per week?
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
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PART 4 CLAIM DETAILS *(If additional space is needed, attach a separate page)*

DRUG EXPENSES		
Patient Name	Number of Receipts	Total Charge

OTHER EXPENSES		
Type of Expense	Nature of Illness	Total Charge

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.

Plan Member's Signature _____ Date _____

Clear