THE **Great-West Life** ASSURANCE COMPANY

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.

Please print

PART 1: EMPLOYEE'S STATEMENT

PLAN NUMBER	DIVISION NO.	PLAN NAME
51257		THE CORPORATION OF THE CITY OF BRAMPTON

EMPLOYEE IDENTIFICATION NUMBER

EMPLOYEE NAME

DATE OF BIRTH Year Month Day

ADDRESS: NUMBER AND STREET TOWN PROVINCE POSTAL CODE

PHONE # HOME: WORK:

COORDINATION OF BENEFITS:

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 _____

Is any member of your family (other than yourself) insured as an employee under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's

date of birth _____ / _____
Day Month

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

SEND THIS CLAIM TO:

Great-West Life Health & Dental Benefits
P.O. Box 3050
Winnipeg MB R3C 4E5
1-800-957-9777
(204) 942-3589

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?
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	

CLAIM DETAILS

Patient Name	DRUG EXPENSES: Number of Receipts	DRUG EXPENSES: Total Charge	OTHER EXPENSES: Type of Expense	OTHER EXPENSES: Nature of Illness	OTHER EXPENSES: 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 _____