THE Great-West Life ASSURANCE COMPANY

PEBA EXTENDED HEALTH CARE PLAN EMPLOYEE CLAIM FORM

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See PART 9.

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.

PART 1 - Plan Member Information (1)

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact the Employee Service Centre or your Employer.

- ☐ PS / GE SGEU and CUPE 600-3 or 600-5 (168850)
- ☐ Out-of Scope Management (168853)

Plan member I.D. number (This number can be located on your 3 in 1 Benefits Card)

Plan Member Name

Last name	First name

Plan Member Address (Please ensure address is current with your employer)

Number and street

City or town	Province	Postal code

Date of birth:

Day	Month	Year

Language preference: ☐ English ☐ French

PART 2 - Coordination of benefits (2)

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No If yes, please provide:

Name of insurance company

Plan number

Plan member I.D. number

If spouse's plan, please provide spouse's date of birth:

Day	Month	Year

2. Is treatment required as the result of an accident? ☐ Yes ☐ No

3. Is a claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No

PART 3 - Patient information (3)

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth Day	Month	Year	If child over 18 years: Full time student Yes	No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	No
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐

PART 4 - Prescription drug expenses (4)

For all prescription drug claims

Attach all original receipts.
- Patient name, date of purchase, drug identification number and drug name.

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Great-West Life
Healthcare Expenses Statement

PART 5 - Paramedical Expenses (5)

For chiropractor, physiotherapist, massage therapist, psychologist, etc.

Attach original receipts. Receipts must indicate the:
- Patient name, length and type of service and date of service
- Healthcare provider's name, address, phone number, designation and professional association
- Date last paid by provincial plan (if applicable)

Provider's name	Type of service	Phone number

PART 6 - Medical Expenses (6)

For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis.
Receipts must indicate the:
- Patient name, date of service and description of item purchased
- Provider's name, address and telephone number
- Provincial plan statement of payment (if applicable)

PART 7 - Visioncare Expenses (7)

Glasses, contact lenses and eye exams.

Attach original receipts.
Reason for purchase of lenses? (check all that apply)

- ☐ Initial prescription
- ☐ Prescription change
- ☐ Loss or breakage
- ☐ None of the above

PART 8 - Confirmation, Authorization and Signature (8)

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 or dentalcare 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.

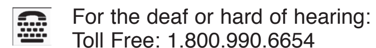
Plan Member signature X ______________________

Date: Day ____ Month ____ Year ____

PART 9 - Submitting Your Claim (9)

Please send your claim to the Benefit Payment Office address below.

Please remember the following when submitting claims:
- All claims must be submitted within 15 months from the date of service.
- Submit only original itemized receipts. Attach all receipts to this claim form.
- GWL does not return receipts. Keep a copy of the receipt if necessary.
- Include any required physician referrals or orders.



Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7

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