

PEBA EXTENDED HEALTH CARE PLAN RETIREE 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											
<p>You must complete this section fully.</p> <p>If you are unsure of your plan name, plan number or plan member I.D. number, please contact Great-West Life.</p>	<div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> PS / GE SGEU Retiree (168851) <input type="checkbox"/> CUPE 600 Retiree (168852) <input type="checkbox"/> Out-of Scope Management Retiree (168854) </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Plan member I.D. number (This number can be located on your 3 in 1 Benefits Card) </div> <div style="margin-top: 5px;"> <p>Plan Member Name</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px;">Last name</td> <td style="border: 1px solid black; padding: 2px;">First name</td> </tr> </table> </div> <div style="margin-top: 5px;"> <p>Plan Member Address</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Number and street</div> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px; width: 60%;">City or town</td> <td style="border: 1px solid black; padding: 2px; width: 15%;">Province</td> <td style="border: 1px solid black; padding: 2px; width: 25%;">Postal code</td> </tr> </table> </div> <div style="margin-top: 5px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px; width: 20%;">Date of birth:</td> <td style="border: 1px solid black; padding: 2px; width: 15%;">Day</td> <td style="border: 1px solid black; padding: 2px; width: 15%;">Month</td> <td style="border: 1px solid black; padding: 2px; width: 15%;">Year</td> <td style="width: 35%; vertical-align: top;"> <p>Language preference:</p> <input type="checkbox"/> English <input type="checkbox"/> French </td> </tr> </table> </div>	Last name	First name	City or town	Province	Postal code	Date of birth:	Day	Month	Year	<p>Language preference:</p> <input type="checkbox"/> English <input type="checkbox"/> French
Last name	First name										
City or town	Province	Postal code									
Date of birth:	Day	Month	Year	<p>Language preference:</p> <input type="checkbox"/> English <input type="checkbox"/> French							

PART 2 - Coordination of benefits 2				
<p>Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.</p>	<p>1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide:</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Name of insurance company</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Plan number</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Plan member I.D. number</div> <p>If spouse's plan, please provide spouse's date of birth:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px; width: 20%;">Day</td> <td style="border: 1px solid black; padding: 2px; width: 20%;">Month</td> <td style="border: 1px solid black; padding: 2px; width: 20%;">Year</td> </tr> </table>	Day	Month	Year
Day	Month	Year		
	<p>2. Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is a claim being made for Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

PART 3 - Patient information 3						
<p>Complete for all expenses; one line per patient.</p>	Patient name	Relationship to plan member	Date of birth	If child over 18 years	Does Patient Reside with Plan Member?	
			Day Month Year	Full time student Yes No	If employed, how many hours worked per week?	Yes No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 4 - Prescription drug expenses 4	
<p>For all prescription drug claims</p>	<p>Attach all original receipts.</p> <ul style="list-style-type: none"> • Patient name, date of purchase, drug identification number and drug name.

PART 5 - Paramedical Expenses

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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

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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

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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

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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 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.

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.

Plan Member signature X _____

Date:

PART 9 - Submitting Your Claim

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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.

Questions? Call Toll Free: 1.800.957.9777

Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7

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