THE Great-West Life ASSURANCE COMPANY

PEBA RETIREES
STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Please complete both sides of this form and mail to Great-West Life, Attention: Out-of-Country Claims Department PO Box 6000 Winnipeg MB R3C 3A5.

When submitting your claim, be sure to attach the required provincial forms available to you by visiting www.greatwestlife.com or by calling our Out-of-Country Claims Department at 1.800.957.9777.

Completion of **these** forms will allow us to pay eligible claims and coordinate payment directly with your provincial health plan or with any other insurance carriers.

GENERAL INFORMATION

Name of Employee _____

Complete Mailing Address _____

_____ Phone Number _____

☐ PS/GE SGEU Retirees (168851) ☐ CUPE 600 Retirees (168852) ☐ Out-of-Scope Management Retirees (168854)

I.D. Number _____

I authorize the release of any information or record(s) requested in respect of this claim to Great-West Life or its agents and certify that the information given herein is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

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.

PATIENT INFORMATION

Name of Patient _____ Birthdate _____

Relationship to Employee _____ Purpose for Travelling _____

Date of Departure _____ Scheduled Return Date _____

Actual Return Date _____ Country Visited _____ Currency Used _____

Please provide a brief description of the illness/injury which required treatment outside Canada:

_____

_____

_____

_____

Date of initial onset of symptoms _____ 1st date you received medical attention for these symptoms _____

Prior to leaving Canada, was the patient aware of, or receiving treatment for this condition? ☐ Yes ☐ No

If yes, what was the last treatment date in Canada? _____

I authorize Great-West Life to make payment directly to the providers of the service.

Employee's Signature _____

STATEMENT OF EXPENSES

Total number of invoices/bills included with this claim _____

Please itemize the expenses below. Attach a separate page if additional space is needed.

DATE	PROVIDER	AMOUNT
	TOTAL DOLLAR VALUE OF BILLS SUBMITTED	**$**

STATEMENT OF OTHER INSURANCE

Are you or any other member of your immediate family entitled to travel and/or medical insurance benefits under any other policy, including other group coverage through employment, individual/private travel plans, or credit card plans that will cover a portion of this claim?
☐ **YES** ☐ **NO**

If Yes, please provide the following information:

Type of other Coverage: (group, individual, credit card)		**Name and phone number of Other Carrier:**	
Policy or Plan Number:		**I.D. Number:**	

Have you sent a claim and/or otherwise contacted the other carrier about this claim? ☐ **YES** ☐ **NO**

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before any benefits can be paid.

I _____ *hereby authorize Great-West Life and it's agents to*
(signature)
coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Great-West Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Great-West Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.

Clear