

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1.800.957.9777

Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 0E6

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

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.

Please print

PART 1 EMPLOYEE INFORMATION					
PLAN NUMBER 51189	DIVISION NUMBER	PLAN NAME I.B.E.W. LU. 353 WELFARE PLAN			
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME			DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET		TOWN	PROVINCE	POSTAL CODE	PHONE #
		HOME:		WORK:	

FOR ACTIVE MEMBERS ONLY:

DO YOU WANT ANY UNPAID PORTION OF YOUR CLAIM PROCESSED THROUGH YOUR HEALTHCARE SPENDING ACCOUNT? YES NO
IF CLAIMING FOR REIMBURSEMENT FROM THE HEALTHCARE SPENDING ACCOUNT, ARE YOU ENTITLED TO CLAIM A MEDICAL EXPENSE TAX CREDIT UNDER THE INCOME TAX ACT (CANADA) FOR THE PATIENT? YES NO

PART 2 COORDINATION OF BENEFITS	
Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date, location and explain how accident happened _____	
Is a claim being made for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 3 DEPENDENT INFORMATION							If child over 18 years			
Patient Name	Relationship to Employee	Date of Birth			Does patient reside with you? YES NO	Full-Time Student? YES NO	If student, how many hours per week?	Employed?		How many hours worked per week?
		Year	Month	Day				YES	NO	
					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		
					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		

PART 4 CLAIM DETAILS (If additional space is needed, attach a separate page)					
DRUG EXPENSES			OTHER EXPENSES		
Patient Name	Number of Receipts	Total Charge	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.

Employee's Signature _____ Date _____