THE Great-West Life ASSURANCE COMPANY

# SELECTPAC HEALTHCARE VISIONCARE EXPENSES STATEMENT

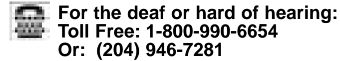
Great-West Life
your Benefits Solutions People

**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.

**SEND THIS CLAIM TO:**

**Winnipeg Benefit Payments**
**P.O. Box 3050**
**Winnipeg MB R3C 4E5**
**Toll Free: 1-800-957-9777 Or: (204) 942-3589**



**For the deaf or hard of hearing:**
**Toll Free: 1-800-990-6654**
**Or: (204) 946-7281**

*Please print*

## PART 1 EMPLOYEE INFORMATION

| PLAN NUMBER | DIVISION NUMBER | PLAN NAME | |
|---|---|---|---|
| EMPLOYEE IDENTIFICATION NUMBER | EMPLOYEE NAME | | DATE OF BIRTH (Year / Month / Day) |
| ADDRESS: NUMBER AND STREET | TOWN | PROVINCE | POSTAL CODE |
| PHONE # HOME: | WORK: | | |

## PART 2 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, name of family member ____________

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: ______ / ______ / ______ (Day / Month / Year)

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

## PART 3 DEPENDENT INFORMATION

| Patient Name | Relationship to Employee | Date of Birth Year | Month | 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? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | |

## PART 4 CLAIM DETAILS *(If additional space is needed, attach a separate page)*

**DRUG EXPENSES**

| Patient Name | Number of Receipts | Total Charge |
|---|---|---|
| | | |
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**MEDICAL/VSIONCARE EXPENSES**

| Type of Expense | Nature of Illness | Total Charge |
|---|---|---|
| | | |
| | | |
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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. 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 to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature ____________ Date ____________

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