

**PART 1 – TO BE COMPLETED BY THE PLAN MEMBER**

PLAN NUMBER  138100  158100

LAST NAME	GIVEN NAME AND INITIAL	I.D. NO.
MAILING ADDRESS		
CITY	PROVINCE	POSTAL CODE
TELEPHONE NO.		

1. Name of Plan Sponsor \_\_\_\_\_  
 Base Plan Policy Number \_\_\_\_\_ Plan Member ID \_\_\_\_\_

2. Is this claim for treatment of a dependant?  Yes  No  
 If child 18 years or older: Full-time student?  Yes  No      Employed?  Yes  No  
 If yes, name of dependant \_\_\_\_\_ Birthdate of dependant \_\_\_\_\_ Relationship to plan member \_\_\_\_\_  
Day/Month

3. If claim was due to an accident, please provide location of accident \_\_\_\_\_  
 Date of accident \_\_\_\_\_ How it occurred \_\_\_\_\_

4. Do you have other coverage for these expenses?  Yes  No  
 If yes, name of other insurance company and policy number \_\_\_\_\_ Name of plan member \_\_\_\_\_

5. If yes to question 4 and patient is a dependent child, please confirm your birthdate \_\_\_\_\_  
Day/Month  
 and your spouse's birthdate \_\_\_\_\_  
Day/Month

*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.

Plan Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

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.

Benefits will be assigned to the provider of service unless receipts are submitted with the claim indicating that payment has been made. The patient is financially responsible for charges **not** covered by this plan.

**PART 2 – ATTENDING PHYSICIAN/PROVIDER'S STATEMENT**

Physician Code	Date of Service			Charge	Diagnosis (complications) and Procedures – Please provide description and details of physician code(s).
	Day	Month	Year		

Date of hospital confinement: From \_\_\_\_\_ To \_\_\_\_\_

**PLEASE PRINT**

Physician/Provider's Name \_\_\_\_\_

Physician/Provider's Address \_\_\_\_\_

Physician/Provider's Postal Code \_\_\_\_\_ Physician/Provider's Telephone Number \_\_\_\_\_

Physician/Provider's Signature \_\_\_\_\_

(The Physician/Provider's signature, or an original receipt, is required in order to process benefits.)

**PLEASE SEE OVER**

**TO BE COMPLETED BY PROVIDER OF SERVICE**

1. LABORATORY    Name of Facility \_\_\_\_\_  
Address of Facility \_\_\_\_\_  
Facility's Postal Code \_\_\_\_\_ Facility's Telephone No. \_\_\_\_\_  
Referring Physician's Name \_\_\_\_\_

DATE OF SERVICE	PHYSICIAN CODE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. RADIOLOGY    Name of Facility \_\_\_\_\_  
Address of Facility \_\_\_\_\_  
Facility's Postal Code \_\_\_\_\_ Facility's Telephone No. \_\_\_\_\_  
Referring Physician's Name \_\_\_\_\_

DATE OF SERVICE	PHYSICIAN CODE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. OTHER EXPENSES

DATE OF SERVICE	CHARGE	DIAGNOSIS AND DESCRIPTION OF SERVICES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician/Provider's Signature \_\_\_\_\_

**Forward completed claim form and original receipts to:**  
The Great-West Life Assurance Company  
Individual Health Unit  
P.O. Box 6000  
Winnipeg, Manitoba R3C 3A5  
Telephone: 1-866-430-2863