Healthcare Expenses Statement

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
3. Send to the appropriate Benefit Payment Office for your plan. See PART 10.

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?

Go to http://groupnet.canadalife.com for details.

THIS IS A: ☐ **Claim for benefits** ☐ **Pretreatment/estimate**

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 their behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - Confirmation, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Canada 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 Canada 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 Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member signature X ______________________

Date: Day ___ Month ___ Year ___

PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name: CATHOLIC INDEPENDENT SCHOOLS OF VANCOUVER ARCHDIOCESE

Plan number: 335645

Plan member I.D. number: ___

Plan Member Name

First name: ___ Last name: ___

Plan Member Address

Number and street: ___ City or town: ___ Province: ___ Postal code: ___

Date of birth: Day ___ Month ___ Year ___

Language preference: ☐ English ☐ French

PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to insurance under any other plan for the expenses being claimed? ☐ Yes ☐ No

   If yes, please answer the questions below.

2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child

   First Name ______________________ Last Name ______________________

3. If the patient is a dependent child, please provide spouse's date of birth: Day ___ Month ___
4. Is the other insurance also with Canada Life? ☐ Yes ☐ No*

   If yes, please provide: Canada Life plan number ______________________ ID Number ______________________

5. Is treatment required as the result of an accident? ☐ Yes ☐ No

   If yes, what kind of accident? ☐ Motor Vehicle ☐ If other, please explain. ______________________

6. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

*If the other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach the other insurer Explanation of Benefits (EOB) to this claim. An EOB is required even if no benefits were paid by the other insurance.

PART 4 - Patient Information - Complete for all expenses; one line per patient.

Patient name First name/Last name	Patient's Relationship to plan member			Patient's Date of birth			If child over 18 years				Does Patient Reside with Plan Member?	
							Full time student			If employed, how many hours worked per week?		
	Self	Child	Spouse	Day	Month	Year	hours per week	Yes	No		Yes	No
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑

PART 5 - Claim Details - If additional space is needed, attach a separate page.

Patient Name - First name/Last name	Type of Expense	Nature of Illness

PART 6 - Prescription Drug Expenses - Credit card receipts and/or debit slips alone are insufficient. Official pharmacy or clinic/physician receipts are required.

All receipts must include:
- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

Please note, receipts for drugs dispensed in Ontario must include the dispense fee.

PART 7 - Paramedical Expenses - For chiropractor, physiotherapist, massage therapist, psychologist, etc.

All receipts must include:
- Patient name
- Date of service
- Name of treatment provided
- Charge for each service
- Provider's name, address, telephone number, professional designation and professional association
- Amount paid by provincial plan if applicable

PART 8 - Medical Expenses - For medical equipment, appliances and services.

All receipts must include:
- Patient name
- Date item was received
- Name of item purchased or a detailed description of the services or supplies
- Charge for each item/service
- Provider’s name, address, telephone number and professional designation
- Amount paid by provincial plan if applicable

PART 9 - Visioncare Expenses - Laser eye surgery, glasses, contact lenses and eye exams.

Receipt details

All receipts must include:
- Patient name
- A breakdown of charges for lenses & frames or eye exam
- Date eyewear was received
- Date the eye exam was performed and paid for

Patient Name First name/Last name	Reason for purchase of lenses (check all that apply)			
	Initial prescription	Prescription change	Loss or breakage	None of these reasons
	❑	❑	❑	❑
	❑	❑	❑	❑
	❑	❑	❑	❑

PART 10 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free: 1.800.957.9777

Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511

Clear