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.

Please print

EMPLOYEE'S STATEMENT

PLAN NUMBER	DIVISION NO.	PLAN NAME
EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE NAME	DATE OF BIRTH Year Month Day
ADDRESS: NUMBER AND STREET / TOWN / PROVINCE / POSTAL CODE		PHONE # HOME: WORK:

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" to either question above, and the patient is a dependent child, please provide spouse's date of birth _____ / _____ (Day / Month)

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

SEND THIS CLAIM TO:

Montreal Benefit Payments
Place Bonaventure
Suite 5800
800 de la Gauchetière St. W
Montreal QC H5A 1B9
1-800-663-2817
(514) 878-1288
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654
Phone: (204) 946-7281

DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth Year	Mth	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?
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CLAIM DETAILS

Patient Name	DRUG EXPENSES: Number of Receipts	DRUG EXPENSES: Total Charge	MEDICAL/VISIONCARE EXPENSES: Type of Expense	Nature of Illness	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

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 _____

CLEAR

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