THE Great-West Life ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT
(Medical, Vision, Drugs)

SEND THIS CLAIM TO:

The Great-West Life Assurance Company
Individual Health Unit
P.O. Box 6000
Winnipeg, MB R3C 3A5

For inquiries call: 1-866-430-2863

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 plan are submitted by the policyowner. We may exchange personal information about claims with the policyowner and/or a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

POLICYOWNER INFORMATION

Policy Number __/__/__/__/__/__/__/ - __/__/__/__/__/__/__/__/__/

Policyowner Name (please print)____

Policyowner Address ____

Phone Number: Home________________________ Work ________________________

COORDINATION OF BENEFITS

1. Are you or any other member of your family entitled to benefits from any other source? ☐ Yes ☐ No

   If Yes, name of family member insured____

   Name of other insurance company____

   Policy number____

2. Is treatment required as the result of an accident? ☐ Yes ☐ No If Yes, give date, location and explain how the accident happened.

   ____

3. If patient is a dependent child, please provide spouse's date of birth. ______ /______ /______
   Day Month Year

DEPENDANT INFORMATION

Patient Name	Relationship to Policyowner	Date of Birth			Does patient reside with you?		Full-Time Student?		If child over 18 years			
		Year	Month	Day	YES	NO	YES	NO	If student, how many hours per week?	Employed? YES	Employed? NO	How many hours worked per week?
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	

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

DRUG EXPENSES

Patient Name	Number of Receipts	Total Charge

OTHER EXPENSES

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. I authorize Great-West Life, any healthcare provider, my plan administrator, (if applicable) 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 certify that the information given is true, correct and complete to the best of my knowledge.

Policyowner's Signature ____ Date ____________________

M635D(IHP) BIL-1/07

©The Great-West Life Assurance Company ("Great-West Life"), all rights reserved. Any modification of this document without the express written consent of Great-West Life is strictly prohibited.