THE Great-West Life ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT

SEND THIS CLAIM TO:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
Toll Free: 1-800-263-5742 Or: (519) 435-6903

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

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

PART 1 EMPLOYEE INFORMATION

PLAN NUMBER	DIVISION NUMBER	PLAN NAME
157493		**CAPREIT LIMITED PARTNERSHIP**

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: _____ / _____ / _____ (Year / Month / Day)

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

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, 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.

Employee's Signature _____ Date _____

CLEAR