

## **Healthcare Expenses Statement**

With Healthcare Spending Account

## **INSTRUCTIONS**

- 1. Complete page 1 and 2 of this form in full.
- 2. Sign and date the form.
- 3. Please retain copies for your files as original receipts will not be returned.
- 4. Send to the appropriate Benefit Payment Office for your plan.

Benefits to be paid from:							
Healthcare Plan Only							
Healthcare Spending Accoun	t Only						
Both							

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

See PART 9.	,p. op	,		p.a	the cl	aims.					
PART 1 - Plan M	lember Informa	tion									1
You must complete this	Plan name										
section fully.	Plan number Plan member I.D. number										
If you are	Plan Member Name										
unsure of your plan name, plan number or	Last name First name										
plan member		n Member Address									
I.D. number, please contact	Number and street										
your plan administrator.	City or town							Province	Postal o	ode	
	Day	,	Month		Yea	ar		Languag	o profess	nooi	
	Date of birth:							Engli		French	
PART 2 - Coordi	ination of benef	its									2
Complete this	1. Are you, or a						nder any oth	er plan fo	or the ex	cpenses	
section to	ection to being claimed?  Yes  No If yes, please provide:								a		
indicate whether you or any	Plan number  motor vehicle accident?  Yes No  3. Is a claim being made for Workers'							u			
member of your family have											
benefits											
coverage from any other plan.	Plan member I.D. number  Compensation Benefits?  Yes No										
	If spouse's plan, please provide spouse's date of birth:  Day  Month  Year					 -					
PART 3 - Patient	t information										3
Complete for all								over 18 ye			
expenses; one line per patient.	Patient n	ame	Relationship to	ro r	Date of I Day Month		Full time student hours per Yes	hov hour	nployed, w many s worked r week?	Reside v	Patient vith Plan ber? No
				$\dashv$			week				
				$\dashv$							
PART 4 - Prescr	iption drug exp	enses									4
For all prescription drug claims			ourchase, drug	identi	fication ı	numbei	r and drug n	ame.			

## Canada Life Healthcare Expenses Statement

PART 5 - Parame	edical Expenses							
For chiropractor, physiotherapist, massage therapist, psychologist, etc.	Attach original receipts. Receipts must indicate the:  • Patient name, length and type of service and date of service  • Healthcare provider's name, address, phone number, designation and professional association  • Date last paid by provincial plan (if applicable)							
	Provider's name	Type of service	Phone number					
ART 6 - Medical	Expenses			(				
For medical equipment, appliances and services.	Receipts must indicate the:  • Patient name, date of so • Provider's name, address	recommendation from prescribing phervice and description of item purchass and telephone number nt of payment (if applicable)		ignosis.				
PART 7 - Visiono	are Expenses							
Laser eye	Attach original receipts.							
surgery, glasses, contact lenses	Reason for purchase of lens							
and eye exams.	Initial prescription None of the above	Prescription change	Loss or breakage					
PART 8 - Confirn	nation, Authorization and S	Signature						
		ect and complete to the best of my knowledge. I ce t my spouse and/or dependents are eligible under t		ces being claimed have				
certify that I am claiming	g expenses that were incurred by myself o	or a person(s) for whom I am entitled to claim a med	ical expense credit under the	Income Tax Act (Canada				
our employer or plan sp	onsor and to the appropriate law enforce	• •						
administering the group administrators of governing	benefits plan. I authorize Canada Life, an ment benefits or other benefits programs mation when necessary for these purpos	acy. Personal information that we collect will be using healthcare or dentalcare provider, my plan admins, other organizations or service providers working es. I understand that personal information may be	nistrator, other insurance or ro with Canada Life located witi	einsurance companies, hin or outside Canada,				
	• •	Life and its affiliates' internal data management an						
For a copy of our Privacy Canada Life's Chief Com	r Guidelines, or if you have questions abo pliance Officer or refer to <u>www.canadalii</u>	out our personal information policies and practices fe.com.	(including with respect to ser	rvice providers), write to				
Plan Member signatu	re <u>X</u>		Date: Day Mont	Year				
PART 9 - Submit	ting Your Claim							
Discourse	laim to the Benefit Payment C	office below. If blank, please consult yo	ur plan administrator	for the address.				
Please send your o								
	Fron: 1 800 957 9777							
Questions? Call Toll	Free: 1.800.957.9777	Deaf or hard of hearing and require access	; to a telecommunication	ns relay service?				
_	/ments Main	<b>Deaf or hard of hearing and require acces</b> Please contact us: TTY to Voice: 711	s to a telecommunication	ns relay service?				