

HEALTHCARE EXPENSES STATEMENT (Medical, Vision, Drugs)

Attach original receipts for each expense and fully itemize the expenses in the space provided below. Your receipts will not be returned to you. You will receive an itemized statement along with our payment or Explanation of Benefits, which you can use for Income Tax purposes.

Please be sure to answer all questions. This claim will be returned to you if it is incomplete or contains errors. For inquiries, call Great-West Life, 1-866-430-2863.

Please print

POLICYOWNER INFORMATION	
Policy Number	___/___/___/___/___/___ - ___/___/___/___/___/___
Policyowner Name (please print)	_____
Policyowner Address	_____
Phone Number: Home	_____ Work _____

COORDINATION OF BENEFITS	SEND THIS CLAIM TO:
1. Are you or any other member of your family entitled to benefits from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of family member insured _____ Name of other Insurance Company _____ Policy number _____	The Great-West Life Assurance Company Individual Health Unit P.O. Box 6000 Winnipeg, Manitoba R3C 3A5 For inquiries, call: 1-866-430-2863
2. Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give date, location and explain how the accident happened _____	
3. If patient is a dependant child, please provide spouse's date of birth. _____ / _____ / _____ DAY MONTH YEAR	

DEPENDANT INFORMATION						If child over 18 years						
Patient Name	Relationship to Policyowner	Date of Birth			Does patient reside with you?		Full-Time Student?		If Student, how many school hours per week?	Employed?		How many hours worked per week?
		Year	Mth	Day	YES	NO	YES	NO		YES	NO	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

CLAIM DETAILS			DRUG EXPENSES			OTHER EXPENSES		
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge			

(If additional space is needed, attach separate page)

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the benefit plan. I authorize Great-West, any healthcare provider, the plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

SIGNATURE OF POLICYOWNER _____ **DATE** _____