

Group Benefits

Supplementary Health and Hospital Insurance Claim

Province of Ontario Employee's Group Insurance Plan

- All drug receipts must show either the name of the drug or the drug identification number (D.I.N.)
- Claims will not be honoured later than the end of the calendar year following the year in which the expense was incurred. If you terminate coverage (due to resignation, transfer from OPSEU to Management, etc., or retirement or death) claims must be submitted within 90 days of date of termination.
- If you are unsure about coverage for a particular expense, please call Manulife Financial directly at **1-800-268-6195**.

Please retain copies for your files as original receipts will not be returned.

1 Employee information

Plan no. 15900	WIN ID no.	Plan sponsor Province of Ontario			
Employee name (first, middle initial, last)			Birthdate (dd/mmm/yyyy)		
Employee address (number, street and apt.)		City or town	Province	Postal code	
Mailing address, if different (no., street, apt., dept. name and floor)		City or town	Province	Postal code	
Are you, your spouse or dependents covered under any other plan for the expenses being claimed? <input type="radio"/> Yes <input type="radio"/> No If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:					
Spouse's date of birth (dd/mmm/yyyy)	Spouse's name (first, middle initial, last)		Name of spouse's insurance company		
Are any expenses incurred as a result of an accident? <input type="radio"/> Yes <input type="radio"/> No If "Yes," specify:					
Date of accident (dd/mmm/yyyy)	Patient's name		Details		

Please provide additional accident details on a separate sheet if insufficient space available.

2 Banking information for direct deposit

To have this and all future claims payments deposited directly into your bank account, attach a void cheque to this claim form and indicate "Yes," in the box below.

Yes, I have attached a void cheque and would like all my future claims payments deposited into this account.

Electronic claim statements

To have this and all future claims statements sent to you electronically, you must register to the Plan Member Secure Site. Log on to www.manulife.ca/groupbenefits for more information.

3 Patient and claim information

Complete for all expenses. Use one line per patient. Attach list if insufficient space available.

Patient's name	Date of birth (dd/mmm/yyyy) (1st Claim only)	Relationship to employee (1st Claim only)	Drugs		Other medical expenses e.g. eye glasses, hearing aids, chiropractor, orthotics	
			Yes	No	Yes	No

Additional child information

Complete only if patients listed above include dependent children.

Child's name	Marital status		Financially dependent?		If age 21 or over, full-time student?	
	Married	Single	Yes	No	Yes	No
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please complete page 2.

4 Employee authorizations and declaration

I authorize the release of any information or records requested in respect of this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

I authorize the use of my WIN ID number for the purpose of tax reporting and if my WIN ID number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- Our employees and representatives in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

Signature of employee

Date (dd/mmm/yyyy)

5 Mailing instructions

Please mail your completed claim form and receipts to the address shown.

MANULIFE FINANCIAL
GROUP BENEFITS
PO BOX 1657
WATERLOO ON N2J 4W5
1-800-268-6195