THE
Great-West Life
ASSURANCE COMPANY

Healthcare Expenses Statement
With Healthcare Spending Account

Benefits to be paid from:
- ☑ Healthcare Plan Only
- ☐ Healthcare Spending Account Only
- ☐ Both

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. See PART 9.

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.

PART 1 - Plan Member Information (1)

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name: **MOTION PICTURE WORKERS HEALTH BENEFIT TRUST**

Plan number: **58197**

Plan member: ID number

Plan Member Name

Last name | First name

Plan Member Address

Number and street

City or town | Province: BC | Postal code

Date of birth: Day | Month: January | Year

Language preference: ☑ English ☐ French

PART 2 - Coordination of benefits (2)

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No If yes, please provide:

Name of insurance company

Plan number

Plan member I.D. number

If spouse's plan, please provide spouse's date of birth:

Day | Month: January | Year

2. Is treatment required as the result of a motor vehicle accident? ☐ Yes ☐ No

3. Is a claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No

PART 3 - Patient information (3)

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 18 years: Full time student hours per week	Full time student Yes	Full time student No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	Does Patient Reside with Plan Member? No
				☐	☐		☐	☐
				☐	☐		☐	☐
				☐	☐		☐	☐
				☐	☐		☐	☐
				☐	☐		☐	☐

PART 4 - Prescription drug expenses (4)

For all prescription drug claims

Attach all original receipts.
- Patient name, date of purchase, drug identification number and drug name.

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Great-West Life
Healthcare Expenses Statement

PART 5 - Paramedical Expenses 5

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

PART 6 - Medical Expenses 6

For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis. Receipts must indicate the:
- **Patient name, date of service and description of item purchased**
- **Provider's name, address and telephone number**
- **Provincial plan statement of payment (if applicable)**

PART 7 - Visioncare Expenses 7

Laser eye surgery, glasses, contact lenses and eye exams.

Attach original receipts.
Reason for purchase of lenses? (check all that apply)

☐ **Initial prescription** ☐ **Prescription change** ☐ **Loss or breakage**

☐ **None of the above**

PART 8 - Confirmation, Authorization and Signature 8

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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare or dentalcare 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, located within or outside Canada, to exchange personal information when necessary for these purposes.

I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I certify that the information given is true, correct and complete to the best of my knowledge.

I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

Plan Member signature X_____

Date: Day | Month: January | Year

PART 9 - Submitting Your Claim 9

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free: 1.800.957.9777

Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654