

# 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.  
See PART 9.

### Benefits to be paid from:

- Healthcare Plan Only  
 Healthcare Spending Account 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 the claims.

PART 1 - Plan Member Information <span style="float: right; border: 1px solid white; border-radius: 50%; padding: 2px 5px;">1</span>					
<p><b>You must complete this section fully.</b></p> <p><b>If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.</b></p>	Plan name				
	Plan number			Plan member I.D. number	
	<b>Plan Member Name</b>				
	Last name			First name	
	<b>Plan Member Address</b>				
	Number and street				
City or town			Province	Postal code	
Date of birth:		Day	Month	Year	Language preference: <input type="checkbox"/> English <input type="checkbox"/> French

PART 2 - Coordination of benefits <span style="float: right; border: 1px solid white; border-radius: 50%; padding: 2px 5px;">2</span>	
<p>Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.</p>	<p>1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide:</p> <p style="margin-left: 20px;">Name of insurance company</p> <p style="margin-left: 20px;">Plan number</p> <p style="margin-left: 20px;">Plan member I.D. number</p> <p>If spouse's plan, please provide spouse's date of birth:</p> <p style="margin-left: 20px;">Day      Month      Year</p>
	<p>2. Is treatment required as the result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>3. Is a claim being made for Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

PART 3 - Patient information <span style="float: right; border: 1px solid white; border-radius: 50%; padding: 2px 5px;">3</span>									
Complete for all expenses; one line per patient.	Patient name	Relationship to plan member	Date of birth			If child over 18 years		Does Patient Reside with Plan Member?	
						hours per week	Yes		
			Day	Month	Year	Full time student	If employed, how many hours worked per week?	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"/>

PART 4 - Prescription drug expenses <span style="float: right; border: 1px solid white; border-radius: 50%; padding: 2px 5px;">4</span>	
For all prescription drug claims	<p>Attach all original receipts.</p> <ul style="list-style-type: none"> <li>• Patient name, date of purchase, drug identification number and drug name.</li> </ul>

**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**

I certify that the information given on this claim form 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 dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

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).

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

*At Canada 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 Canada 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 Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.*

*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 Canada Life's Chief Compliance Officer or refer to [www.canadalife.com](http://www.canadalife.com).*

Plan Member signature **X** \_\_\_\_\_

Date:  Day  Month  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  
[www.canadalife.com](http://www.canadalife.com)



**Deaf or hard of hearing and require access to a telecommunications relay service?**

Please contact us:  
TTY to Voice: 711  
Voice to TTY: 1-800-855-0511