STANDARD LIFE

GROUP LIFE & HEALTH

Medical and Paramedical Claim Form

CLAIMS DEPARTMENT

MONTRÉAL
P.O. BOX 4002 POSTAL STATION B
MONTRÉAL, QUÉBEC H3B 4M2

TORONTO
P.O. BOX 4105 POSTAL STATION A
TORONTO, ONTARIO M5W 2P4

IMPORTANT: Please print, ensure that all information is provided and SIGN this form in order to avoid claims processing delays. If you need assistance in completing this form, do not hesitate to contact us at 1 800 499-4415.

I Participant Statement

(complete this section to ensure quick identification)

Policyholder name: THE HINCKS-DELLCREST CENTRE		Policy no.: 014031	Certificate no.
Participant surname	Given name		Initial
Main residence address *(no., street)*			Apt.
City	Province		Postal code
Language: ❑ English ❑ French	Sex: ❑ M ❑ F	Telephone no. *(day)* ( )	Date of birth *(YYYY / MM / DD)*

II Dependents

(complete this section the first time you submit a claim for a dependent child or spouse or whenever there is a change)

Spouse surname	Given name	Date of birth *(YYYY / MM / DD)*

Children

Complete name	Date of birth *(YYYY / MM / DD)*	Sex M F	Full-time student[1]	Confirmation of school attendance Name of educational institution and attendance period
Surname Given name		❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname Given name		❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname Given name		❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname Given name		❑ ❑	❑	Name Start *(YYYY / MM / DD)* End
Surname Given name		❑ ❑	❑	Name Start *(YYYY / MM / DD)* End

[1] ***Student's status:*** *The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.*

Disabled child: *If a child is over the dependent child age limit under your contract and was permanently disabled while considered a covered dependent, please submit the form "Confirmation of total and permanent disability of a dependent child" GE10352 completed by you and the physician.*

III Coordination of benefits

(complete this section if any expenses you are claiming for are covered by another plan)

Name of your spouse's group insurer	Policy no.	Certificate no.

Coverage: **Health insurance** ❑ Single ❑ Family **Dental Care** ❑ Single ❑ Family

Effective date of coordination of benefits *(YYYY / MM / DD)*	Cancellation date of coordination of benefits *(if applicable)* *(YYYY / MM / DD)*

Claiming instructions: *for his/her expenses, your spouse must claim first to his/her insurer. Children's claims must be submitted to the insurer of the parent whose date of birth occurs first in the calendar year. If claim was already processed by another insurer, please submit a copy of their explanation of benefits and copies of receipts.*

Please see reverse »

If you do not need the following section, please detach it.

DIRECT DEPOSIT IS THE PREFERRED METHOD OF PAYMENT BY STANDARD LIFE. IF YOU DO NOT ALREADY USE IT, PLEASE COMPLETE THIS SECTION

Direct deposit - authorization

❑ 1st request ❑ Modification		Policy no.: 014031	Certificate no.
Participant surname	Given name		Telephone no. *(day)* ( )
Financial institution name	Financial institution address		
Type of bank account: ❑ Chequing *(please attach a personalized void cheque)* ❑ Savings *(please provide your banking information in the adjacent section)*	Branch no.	Institution no.	Account no.

I authorize Standard Life to credit all my benefit payments to the account mentioned on this form. I certify that the information provided on this form is accurate, and I agree to inform Standard Life of any subsequent changes. I accept that this agreement may be cancelled at any time by either Standard Life or myself, in writing or verbally.

Participant signature	Date *(YYYY / MM / DD)*	Account holder signature *(if other than participant)*	Date *(YYYY / MM / DD)*
	2005/04/28		2005/04/28

For Standard Life use only	Received *(YYYY / MM / DD)*
	/ /

IV Medical expenses

(the claims expenses must be submitted only when fully paid)

1. If possible, please do not submit a claim until incurred expenses total at least $100 or an amount equivalent to the deductible.
2. For covered expenses exceeding $500, please submit an estimate in writing first to verify eligibility of expenses.
3. Attach original receipts and keep copies for your records. All receipts are destroyed after 60 days. The statement of benefits and copies of your receipts are sufficient for income tax and benefit coordination purposes.

DRUGS	The receipts must show patient name, drug name and drug identification number *(DIN)*.	TOTAL AMOUNT OF YOUR DRUG CLAIMS $_____
OTHER MEDICAL AND PARAMEDICAL EXPENSES	Receipts should indicate the provider name and address, and all dates of visits or any exams and detailed related costs. Always refer to your booklet to confirm coverage for different health practitioners and attach physician referrals where required by your contract.	TOTAL AMOUNT OF YOUR OTHER MEDICAL AND PARAMEDICAL CLAIMS $ _____
VISION CARE	Receipts must indicate the provider name and address, and show separate costs for contact lenses, frames and lenses for glasses, cost and date of eye exams.	TOTAL AMOUNT OF YOUR VISION CARE CLAIMS $ _____

OUT OF COUNTRY

Claims for all medical expenses, except drugs, must first be sent to the provincial plan and then forwarded to Standard Life with provincial proof of payment and copies of all receipts. All receipts must show provider specialty, name, address and telephone number.

Reason for travel	Date of departure *(YYYY/MM/DD)*	Date of return *(YYYY/MM/DD)*

In what country were the expenses incurred?

Are these expenses covered under a travel insurance or other plan? ❑ Yes ❑ No

Were expenses incurred due to an emergency? ❑ Yes ❑ No

V Accident

(if the accident involves dental injury, please complete G2019)

Please describe the accident

Has any portion of these expenses been submitted to a government body for reimbursement *(WSIB, CSST, ...)*? ❑ Yes ❑ No

VI Plan with Health Spending Account

(if applicable)

Do you want any unpaid portion of this claim to be considered under your Health Spending Account? ❑ Yes ❑ No

Note: If your Health Spending Account provides for automatic reimbursement, any unpaid portion will be paid from your Health Spending Account, subject to remaining credits.

The coordination of benefits guidelines will apply.

VII Authorization

I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Standard Life, for the assessment of my claim.

I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life or their authorized agents use the information provided in this form and prior claims under the same plan (if relevant) for the management of my claim and for statistical reports.

I confirm being authorized by my dependents to act on their behalf for their expenses submitted in this claim.

I consent to the use of my Social Insurance Number as my certificate number, and understand that it is my responsibility to contact my employer/plan administrator if I prefer to use another identification number.

I certify that the information contained in this form is true, correct and complete and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life will automatically reject this claim in all or in part.

A photocopy of this authorization is valid as the original.

Participant signature	Date *(YYYY/MM/DD)*
	2005/04/28

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