The Maritime Life Assurance Company

Health Care Expense

SECTION 1 - TO BE COMPLETED BY PLAN MEMBER

DHL Express (Canada) Ltd. **961281**

Plan Sponsor/Employer Policy # Plan Member ID #

Plan Member — Last Name First Name and Initial Date of Birth (yyyy/mm/dd)

Plan Member — Address No. Street City Province Postal Code

1. Do you have a Pay Direct Drug (i.e. MaritimeScript) card? ☐ No ☐ Yes
2. Is this claim a result of traveling outside the country? ☐ No ☐ Yes If yes, from ______ (yyyy/mm/dd) to ______ (yyyy/mm/dd)

Coordination of Benefits

3. Are any of these expenses related to a Workers' Compensation Claim? ☐ No ☐ Yes
4. Are benefits available from another group plan? ☐ No ☐ Yes
   If yes, please provide the following information ______ Insurance Carrier Name ______ Policy Number
5. If other coverage was available and has recently terminated, please provide termination date ______ (yyyy/mm/dd)

The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Maritime Life with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.

Health Care Spending Account Information (If Eligible)

6. Do you want any unpaid balance from this claim reimbursed from your Health Care Spending Account? ☐ No ☐ Yes

Claim Information

Please complete all requested information and list expenses in date order. Use a separate line for each person and attach original receipts. Incomplete forms or photocopied receipts cannot be processed for payment.

Patient Name	Relationship to Employee	Date of Birth (yyyy/mm/dd)	If Dependent Full-time Student?	If Dependent Full-time Work?	Receipt Date (yyyy/mm/dd)	Description of Expense *	Total Charge

* Please identify the type of health expense (eg. drugs, physiotherapy, etc.)

SECTION 2 - DECLARATION & AUTHORIZATION

I authorize The Maritime Life Assurance Company ("Maritime Life") to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Maritime Life will be kept confidential and, where necessary, Maritime Life will be exchanging my personal information. I authorize the following persons to exchange with Maritime Life or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution.

I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Signature of Plan Member (in full) (yyyy/mm/dd)

NS NB PE NL Group Claims Department, 7 Maritime Place, PO Box 1030, Halifax NS B3J 2X5, 902 453 4300

QC Group Claims Department, Bureau 1200, 999 boul de Maisonneuve O, Montréal QC H3A 3L4, 514 288 4300

ON Group Claims Department, Maritime Life Tower, 2 Queen Street East, PO Box 4607 Stn A, Toronto ON M5W 4Z3, 416 687 5007

BC YT NT NU Group Claims Department, Suite 1404, 1055 Dunsmuir Street, PO Box 49284, Vancouver BC V7X 1L3, 604 689 1429

AB MB SK Group Claims Department, Suite 3410, 450 - 1st Street SW, Calgary AB T2P 5H1, 403 750 7320

GB3343B # 961281 10 JUL 03