THE Great-West Life ASSURANCE COMPANY

HEALTHCARE

HEALTHCARE SPENDING ACCOUNT PLAN (SIDE 1)

IMPORTANT: Payment may be delayed if this form is not fully completed.
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.

Please print

PART 1: EMPLOYEE'S STATEMENT

Employee Name _____ Date of Birth _____

Employee Home Mailing Address _____
STREET CITY/TOWN PROVINCE POSTAL CODE

Group or Plan Name **CAPREIT LIMITED PARTNERSHIP** Plan Number **157493** ID Number _____ DIV # _____

1. Are any of your eligible dependents insured as an employee under this plan? ☐ Yes ☐ No

   If yes, name of eligible dependent _____ I.D. Number _____

2. Are you or any of your eligible dependents entitled to medical benefits under any other plan? ☐ Yes ☐ No

   If yes, name of eligible dependent insured _____ Relationship to employee _____

   Name of other insurance Company _____ Policy Number _____

3. If yes to question 1 or 2 above, and the patient is a dependent child, give: Employee's birthdate (Day/Mo.) _____

   Spouse's birthdate (Day/Mo.) _____

4. If patient is other than employee's spouse or child under 21, is employee entitled to claim a medical expense tax credit under the Income Tax Act (Canada) in respect of the patient? ☐ Yes ☐ No

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. I authorize Great-West Life, any healthcare 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 to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

PART 2: DEPENDENT INFORMATION

(To be completed if claim includes any expense for a dependent.)

				If child over 18 years			
Patient Name	Relationship to Employee	Date of Birth Year Month Day	Does patient reside with you?	Full-Time Student?	If student, how many hours per week at school?	Employed?	If yes, how many hours worked per week?
		___ ___ ___	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
		___ ___ ___	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
		___ ___ ___	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
		___ ___ ___	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

PART 3: CLAIM INFORMATION

NOTE: *Please attach a receipt or bill for each item claimed. Receipts and bills, other than those required for government drug plans, are part of our records and will not be returned. The Explanation of Benefits that will accompany our cheque should be kept for your records and for Income Tax purposes.*

A. DRUG CHARGES

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE.

Name of Patient	For each Patient Show Only Date of First and Last Receipt		No.of Receipts	Total Charge
	From	To		$
	From	To		$
	From	To		$
	From	To		$
	From	To		$

Please ask your pharmacist to indicate Prescription Number, Drug Identification Number (DIN) and brand name on each drug receipt submitted.

TURN OVER FOR SIDE 2

HCSA CLAIM EXPENSES ARE REIMBURSED IN THEIR ENTIRETY, DEPENDING ON THE AVAILABLE CREDITS. REQUESTS FOR PARTIAL REIMBURSEMENTS CANNOT BE ACCOMMODATED.

B. OTHER EXPENSES (ambulance, chiropractor & visioncare, etc.)

Name of Patient	Provider of Service	Type of Service	Date of Service	Charge	Nature of Illness

Clear

SEND THIS CLAIM TO:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
Toll Free: 1-800-263-5742 Or: (519) 435-6903

For the deaf or hard of hearing:
Toll Free: 1-800-990-6654
Or: (204) 946-7281

HEALTHCARE CLAIM FORM COMPLETION CHECK LIST

1) HAS THE EMPLOYEE SIGNED THE CLAIM FORM – SIDE 1?

2) HAS ALL OF THE PATIENT/DEPENDENT INFORMATION BEEN COMPLETED – SIDE 1 AND 2?

3) HAS ALL THE NECESSARY CLAIM FORM DOCUMENTATION BEEN ATTACHED TO THIS CLAIM FORM? SUCH AS:

- GREAT-WEST LIFE OR OTHER INSURER'S EXPLANATION OF BENEFITS, (WHERE INSURER HAS ALREADY PROCESSED OR PAID SOME PORTION OF THE CLAIM),
- PROVINCIAL HEALTH PLAN STATEMENT,
- RECEIPTS,
- PRESCRIPTIONS.