Manulife Financial

For your future™

Group Benefits
Fitness Account Claim

This form is to be completed by the plan member. Receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as receipts will not be returned.

1 Plan member information

Plan contract number	Division number	Plan member certificate number	Plan sponsor
86399			Teva Canada Limited

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

2 Claimant information

Complete for all expenses.
Use one line per claimant.

Claimant's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member

3 Claims confirmation

Total amount of **ALL** receipts submitted: **$**

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete and represent no duplication of claims previously submitted to any plan. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of determining eligibility, administration of coverage, payment of this claim, Group Benefits plan administration, audit and the assessment, investigation and overall management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization who has Information relevant to this claim, including health professionals, facilities or providers, club operators, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, and/or its service providers, for the Purposes. **I authorize** Manulife to disclose to my employer benefit amounts paid from the plan for tax reporting purposes. **I understand** that eligible expenses reimbursed under the Taxable Spending Account ("TSA") are defined by my Plan Sponsor and determination for eligibility is wholly within my Plan Sponsors' discretion. **I understand** that eligible expenses reimbursed under the TSA will be added to my T4, by my employer, as taxable income in the year which the claim was incurred. **I understand** that reimbursement of these expenses represents a taxable benefit to me and I am responsible for payment of any income tax on these amounts. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Please sign here

Signature of plan member	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

4 Mailing instructions

- Staple your receipts and, if applicable, your health or dental claim form(s) and insurance carrier's claim statement(s)/explanation of benefit form(s) to the back of the claim form.
- Place your completed claim form in an envelope and mail to this address:

MANULIFE FINANCIAL
GROUP HEALTH CLAIMS
PO BOX 1653
WATERLOO ON N2J 4W1