

HEALTHCARE EXPENSES STATEMENT

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
 Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

Please print

PART 1: EMPLOYEE'S STATEMENT					
PLAN NUMBER 51189	DIVISION NO	PLAN NAME TRUSTEES OF THE WELFARE FUND, I.B.E.W. LOCAL 353			
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME		DATE OF BIRTH Year Month Day	
ADDRESS: NUMBER AND STREET		TOWN	PROVINCE	POSTAL CODE	PHONE: HOME WORK

COORDINATION OF BENEFITS:	SEND THIS CLAIM TO:
Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", name of family member insured _____ Relationship to employee _____ Name of other insurance company _____ Policy Number _____ Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth ____ / ____ Day Month Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" give date, location And explain how accident happened _____ Is a claim being made for Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Great-West Life Health & Dental Benefits P.O. Box 3050 Winnipeg, Manitoba R3C 4E5 1-800-957-9777 (204) 942-3589

DEPENDENT INFORMATION						If child over 18 years						
Patient Name	Relationship to Employee	Date of Birth			Does patient reside with you?		Full-Time Student?		If Student, how many hours per week?	Employed?		How many hours worked per week?
		Year	Mth	Day	YES	NO	YES	NO		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"/>	<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"/>	

CLAIM DETAILS		DRUG EXPENSES		OTHER EXPENSEE		
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge	

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

SIGNATURE OF EMPLOYEE _____ **DATE** _____