Kruger

PLAN #154850

HEALTHCARE EXPENSES STATEMENT

THE Great-West Life ASSURANCE COMPANY

INSTRUCTIONS FOR THE USE OF THIS FORM - SEE ADDITIONAL KEY INSTRUCTIONS ON REVERSE

1. Employee's statement must be completed and signed by the employee, or else it will be returned to the employee.
2. Submit only original receipts and retain copies for your records; photocopies are not acceptable.
3. Receipts will not be returned. Your explanation of benefits statement is sufficient for income tax purposes.
4. Group your receipts by family members, into drug and non-drug expenses and in date order.
5. All claims must be submitted within 15 months of the expense being incurred. Claims submitted after this limit are not covered under the terms of your plan.

EMPLOYEE'S STATEMENT (COMPLETE IN FULL TO AVOID DELAY OF PAYMENT)

Employee's Name (please print) Last | First | Initial | I.D. Number | ☐ Male ☐ Female | Date of Birth Day Month Year

Address Street | Apartment Number

City | Province | Postal Code

Is this claim for services required as the result of an accident? ☐ Yes ☐ No

If yes, how did it happen? _____ Date of accident Day Month Year

Where did it happen? ☐ at home ☐ at work ☐ elsewhere

If dental accident, we require X-rays taken after the accident and prior to treatment (if any)

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR A DEPENDENT

First name plus Last name	Relationship to employee: Spouse	Son	Daughter	Other	Date of Birth: Day Month Year	If dep. child is 21 and over: Student	Handicapped	Total $ Claimed
	☐	☐	☐	☐		☐	☐	
	☐	☐	☐	☐		☐	☐	
	☐	☐	☐	☐		☐	☐	
	☐	☐	☐	☐		☐	☐	
	☐	☐	☐	☐		☐	☐	

If expenses are for "other", please indicate their relationship to the employee. _____

If the patient is a child over 21: a) is he/she a full-time student? ☐ Yes ☐ No If yes, name of school _____

b) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____

COORDINATION OF BENEFITS

1. Is any other member of your family insured as an employee under this plan? ☐ Yes ☐ No

   If yes, name of family member _____

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

   If yes, name of family member 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.) _____ AND

   Spouse's birthdate (Day/Mo.) _____

TOTAL AMOUNT CLAIMED $

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 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.

Date _____ Employee's Signature _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

Additional Key Instructions

It is clear that the financial health and success of a group medical plan is dependent upon the concern and cooperation of employee, employer and administrator. The following is not only a means to assure Great-West Life's prompt and due claim adjudication service, but it is also an information vehicle assisting you, the consumer, to actively contribute to the group medical plan's course of progress.

The bottom line: In order to help us keep the cost of your plan at the lowest possible level, please review the following with care:

1. There are many generic drugs on the market which are considerably less expensive than brand name drugs you may have become accustomed to purchasing. We suggest you make enquiries about these with your pharmacist or doctor and when suitable purchase the least expensive.

2. Cost of drugs may vary significantly between pharmacies; we would suggest you do comparative shopping.

3. The receipts you submit must include the name of the patient, the nature of the treatment or medical supply, the name of the prescribing physician, the date furnished or the date medication was purchased and the amount charged.

MAIL THE COMPLETED FORM DIRECTLY TO GREAT-WEST LIFE AT THE ADDRESS BELOW:

Great-West Life Health & Dental Benefits
Place Bonaventure
Suite 5800
800 de la Gauchetière St. W
Montreal QC H5A 1B9
1-800-663-2817
(514) 878-1288

Great-West Life will send a cheque and explanation of benefits directly to you at the address you indicate on the reverse of this form. Please ensure that you provide your full mailing address.

IMPORTANT: All claims must be submitted within 15 months of the expense being incurred. Claims submitted after this limit are not covered under the terms of your plan.