Manulife Financial

# Group Benefits
# Extended Health Care Claim

*To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.*

## 1 Plan member information

| **Plan contract number** | **Plan member certificate number** | Plan sponsor |
|---|---|---|
| | | |

| Plan member name (first, middle initial, last) | Birthdate (dd/mmm/yyyy) |
|---|---|
| | |

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

Are these expenses eligible for coverage under any type of workers' compensation board? ◯ Yes ◯ No

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

| Spouse's date of birth (dd/mmm/yyyy) | Name of spouse's insurance company | Spouse's plan contract number | Spouse's plan member certificate number |
|---|---|---|---|
| | | | |

### Banking information for direct deposit

To have this and all future claims payments deposited directly into your bank account, attach a void cheque to this claim form and indicate "Yes," in the box below.

◯ Yes, I have attached a void cheque and would like all my future claims payments deposited into this account.

If you have separate plan contract numbers for Health and/or Dental coverage under your Manulife Group Benefits Plan, please include these plan contract numbers (listed on your wallet identification card) in the box below.

### Electronic claim statements

You can view your statements online! We'll even send you an e-mail when they're ready. Go to www.manulife.ca/groupbenefits and select "Plan Member" and enter your plan contract number. You must be registered to use the site. Log in and select, "Electronic Claim Statements" from the navigation bar.

## 2 Patient information

Complete for all expenses. Use one line per patient.

| | | | Complete if patient is a student 18 or older | |
|---|---|---|---|---|
| **Patient's name** | **Date of birth** (dd/mmm/yyyy) (1st Claim only) | **Relationship to plan member** (1st Claim only) | **School and city** | **If employed, hrs worked per week** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 3 Prescription drug expenses

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the drug identification number (D.I.N.) and the name of the prescription drug.
- You are not required to list this information on the form.

## 4 Practitioner's/ Paramedical expenses

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please attach an **itemized statement** and/or receipt stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

***Please complete next page.***

## 5 Equipment and appliance expenses

For equipment and appliance expenses Manulife Financial requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item.

Duration equipment is required. **From** Date (dd/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has rental equipment been returned? ◯ Yes ◯ No

## 6 Vision care expenses

**To be completed by supplier.**

Please enclose an itemized receipt indicating:

- patient's name,
- cost of contact lenses,
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- cost of laser surgery and
- date dispensed.

**Medically necessary contact lenses:**

***Please have the supplier complete and sign below.***

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ◯ Yes ◯ No

Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses? ◯ Yes ◯ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯ Yes ◯ No

Signature of supplier | Date signed (dd/mmm/yyyy)

## 7 Claims confirmation

**NOTE - ORIGINAL RECEIPTS must be attached for all expenses.**

**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. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and 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 with Information, including any medical and health professionals, facilities or providers, 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, its reinsurers and/or its service providers, for the Purposes. **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)

**Print**

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, reinsurers, 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.

## 8 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

**If you live outside Quebec:**
Manulife Financial Group Benefits
Health Claims
P.O. BOX 1653
WATERLOO ON N2J 4W1

**If you live in Quebec:**
Manulife Financial Group Benefits
Health Claims
P.O. BOX 2580, STATION B
MONTREAL QC H3B 5C6