

# Extended Health Care / Drug Claim Form



## Part I: Member Information

Plan Name **STF Members' Health Plan** Group Policy Number **051585** Member Identification Number

Last Name  First Name  Initial  Date of Birth (DD MM YY)

Home Mailing Address  Home Phone

City/Town  Province  Postal Code       School Phone

## Part II: Coordination of Benefits (Please see reverse for complete instructions.)

Yes  No

1. Is any other member of your family entitled to benefits under any other group benefit plan, or as a teacher, under the STF Members' Health Plan?  
If "Yes", name of family member insured   
Relationship to Plan Member  Self  Spouse  Child  
Name of Insurance Carrier  Great West Life  Other (please specify)   
Please provide your spouse's group policy number and employee or Member Identification Number:  
Group Policy Number  Employee or Member Identification Number   
If patient is a dependent child, please provide spouse's day and month of birth (DD MM)

2. Is treatment required as the result of an accident? If "Yes", give date, location and explain how accident happened.

3. Is a claim being made for Worker's Compensation Benefits?

## Part III: Claim Details

Patient's First Name	Relationship to Plan Member	Date of Birth (DD MM YY)	If child is over 18, check if:				Total Number of Receipts
			Full-time Student?	Mentally or Physically Disabled?	Employed? If yes, how many hours per week?		
<input type="text"/>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value=""/> hours	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value=""/> hours	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value=""/> hours	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value=""/> hours	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value=""/> hours	<input type="text"/>
<b>Total Number of Receipts</b>							<input type="text"/>

## Part IV: Member Authorization

I certify that the statements in this claim are true and complete and that all goods or services being claimed have been received by me, and paid for in full. I authorize the Saskatchewan Teachers' Federation, the STF Members' Health Plan and its claim agents, and any person or organization who has relevant personal information about me or my dependants, to exchange information for the purpose of payment of claims, underwriting or administration of the Plan.

Member Signature   Date Signed (DD MM YY)

## How to Submit Your Claim

1. Please complete one claim form for all family members for whom you are claiming expenses.
2. Include your Member Identification Number on your claim form. It is the 10-digit number found on your pay direct Prescription Drug Card, e.g. 0100000000. If you are a teacher on a temporary contract, you will not receive a pay direct Prescription Drug Card. Your Member Identification Number can be found on your confirmation of enrolment letter.
3. Attach original, itemized bills and official receipts for income tax purposes for all expenses. Staple receipts securely to back of claim form. Photocopies, carbon copies, credit card receipts or cash register receipts are not acceptable. (A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits.) Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.
4. Bills and receipts are part of our records and will not be returned. Therefore, please retain copies of your receipts and the Explanation of Benefit that will accompany our cheque or explanation for your files and/or income tax purposes.
5. Mail your completed form directly to the claims office as indicated below.

## Coordination of Benefits

It is important that your plan pays only for benefits for which it is responsible. This is done through a process called Coordination of Benefits. Coordination of Benefits is a group health insurance provision designed to eliminate duplicate payments and determine the order for payment of benefits when there is coverage provided under a spouse's or dependent's group plan. Benefit payments may be coordinated with the benefits provided by any other group plan to provide up to 100% of the eligible expenses, as long as the total amount received from all sources does not exceed the amount of the actual expenses incurred. A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.

A spouse who is covered under his/her employer's plan must first submit his/her claims to that plan and a university student who is covered under a university plan must first submit his/her claims to the university plan. Spouse means your legal spouse or the person who has cohabited with you in a spousal relationship for at least 12 consecutive months.

**Expenses for dependent children must first be submitted to the plan of the parent with the earlier birthday in the year.**

Part II Coordination of Benefits helps us determine the order of payment. Claims for members with a spouse who has coverage under another Great-West Life benefit or who is also covered as a teacher under the STF Members' Health Plan may automatically coordinate benefits. Please be sure to complete this section.

## Health Care Expenses

This section is to be completed when you have extended health care items and drugs, excluding vision care services and supplies. Please provide the patient's name, relationship to you, date of birth, status of child information when 18 years or older, and the total paid receipts for each type of service. Please provide the total number of receipts in the bottom box of this section. You must use the Vision Care Claim Form when claiming reimbursement for vision care services and supplies.

The DIN and prescription number must be clearly visible on your official receipts. Charges for medical services and supplies must be prescribed by an approved practitioner in order to be an eligible charge.

## Reminder

Coverage expenses and limitations apply to each individual covered family member. Frequency limitations and reasonable and customary charges may apply to extended health care charges. Certain items, e.g. private duty nursing, require preauthorization by Great-West Life prior to submission of your claim for reimbursement. The date of service is normally defined as the date the services and supplies were paid for, in full. This may not be the date you incurred the service and may change dependent on the service. If you are not sure when you have reached a frequency limit, please contact Great-West Life as indicated below.

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**Please answer all questions and ensure your form is completed in full. This claim will be returned to you if it is incomplete, or contains errors, and will result in a delay in processing your claim. All claims under this group benefits plan must be submitted through, and signed by, the plan member to:**

**STF Members' Health Plan  
PO Box 1944 STN Main  
Saskatoon SK S7K 3S5**

**For eligibility and claim inquiries call 1-800-667-7762 or 373-1660 in Saskatoon or e-mail: [health@stf.sk.ca](mailto:health@stf.sk.ca) or visit [www.stf.sk.ca](http://www.stf.sk.ca)**

**For claim inquiries call: Great-West Life, 1-800-957-9777 or (204) 942-3589 or visit [www.greatwestlife.com](http://www.greatwestlife.com) and sign onto GroupNet for Plan members.**