Members' Health Plan

THE Great-West Life ASSURANCE COMPANY

Health Claim

Instructions:

- Use this form for all health, prescription drug and vision expenses.
- Claims must be submitted within 15 months from the date the expense was incurred.
- Attach the **original**, itemized receipt(s) for each expense. Keep copies of receipts and the claim statement for your files and/or for income tax purposes.
- Please ensure all sections of the form are complete and signed by the plan member or your form will be returned to you.
- To submit claims online, register for Great-West GroupNet on the Federation website, www.stf.sk.ca.

Mail your claim form(s) and receipt(s) to:

Great-West Life
Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7

For inquiries contact:
Great-West Life 1-800-957-9777; or Members' Health Plan 1-800-667-7762; 306-373-1660 in Saskatoon; or email: health@stf.sk.ca

Part I: Member Information

Plan Name: **Members' Health Plan** Group Policy Number 5 1 5 8 5 Member Identification Number 0 1

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: Co-ordination of Benefits

- Send your claim to your own group plan first. To claim any unpaid amount, send a copy of your claim statement and receipts to your spouse's plan.
- Send your spouse's claims to their plan first, even if the benefit maximum has been reached. To claim any unpaid amount, send a copy of their claim statement and receipts to your plan.
- Claims for dependent children must be submitted to the plan of the parent who has the earlier birthday in the year.

Are you, or any other member of your family, entitled to benefits under any other group plan for the expenses being claimed? ❑ Yes ❑ No

If "Yes," name of family member insured | Relationship to plan member: ❑ Self ❑ Spouse ❑ Child

If other group plan is Great-West Life, please provide the following:

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)

Is treatment required as the result of an accident? ❑ Yes ❑ No If "Yes," give date, location and explain how accident happened.

Is a claim being made for Workers' Compensation benefits? ❑ Yes ❑ No

Part III: Claim Details

- List the names of all persons for whom you are claiming expenses. Ensure each receipt clearly indicates the type of expense being claimed.

Patient's First and Last Name	Relationship to Plan Member	Date of Birth (DD MM YY)	If child is over 18, check if they are a full-time student.	Number of Receipts
	❑ Self ❑ Spouse ❑ Child		❑ Yes ❑ No	
	❑ Self ❑ Spouse ❑ Child		❑ Yes ❑ No	
	❑ Self ❑ Spouse ❑ Child		❑ Yes ❑ No	
	❑ Self ❑ Spouse ❑ Child		❑ Yes ❑ No	

Part IV: Member Authorization

At Great-West Life we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's chief compliance officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any health-care provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside of Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct and complete to the best of my knowledge.

Member Signature X | Date Signed (DD MM YY)

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