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
87220		University of Western Ontario

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

Sign up for direct deposit and electronic claim statements

Receive your claim payments up to 70% faster with direct deposit and enjoy the convenience of seeing your claim statements online.

- Go to www.manulife.ca/groupbenefits and register for the plan member secure site
- Once you've registered, or if you're already registered, log into the secure site and select **Direct deposit for claims** from the menu to the left of the screen
- Enter your banking information

HCSA contract number

87221

◯ Check here to use your Health Care Spending Account (HCSA) to reimburse any unpaid portion of this claim.

(If the patient has health coverage under another plan, you **must** submit any unpaid amount from this claim to that plan **before** using your HCSA.)

2 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy) (1st Claim only)	Relationship to plan member (1st Claim only)	Complete if patient is a student 18 or older	
			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.

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 Claims confirmation

Total amount of ALL receipts submitted **$**

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

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)

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.

7 Mailing instructions

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

MANULIFE FINANCIAL GROUP BENEFITS
HEALTH CLAIMS
PO BOX 1653
WATERLOO ON N2J 4W1