canada life™

# Extended Health Plan Claim Form

BRITISH COLUMBIA BC Public Service | Where ideas work

**INSTRUCTIONS**

1. Complete page 1 and 2 of this form in full.
2. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
3. Send to the appropriate Benefit Payment Office for your plan. See PART 10.

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?

Go to http://groupnet.canadalife.com for details.

THIS IS A: ☐ **Claim for benefits** ☐ **Pretreatment/estimate**

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on their behalf when necessary to confirm eligibility and to mutually manage the claims.

## PART 1 - Confirmation, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

*At Canada 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. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.*

*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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

This information is collected by the British Columbia Public Service under s. 26(c) of FOIPPA. Any questions about the collection and the use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request to AskMyHR and selecting My Team/Organization > Employee & Labour Relations > Other Issues & Inquiries, phoning: 1-877-277-0772 or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard Street, Victoria, BC V8W 2H2.

**Plan Member signature X** _____ **Date:** Day | Month | Year

## PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

**Plan name (Employer Name)**

**Plan number** | **Plan member I.D. number**

**Plan Member Name**

**First name** | **Last name**

**Plan Member Address**

**Number and street** | **City or town** | **Province** | **Postal code**

**Date of birth:** Day | Month | Year

**Language preference:** ☐ English ☐ French

## PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to insurance under any other plan for the expenses being claimed? ☐ Yes ☐ No

   If yes, please answer the questions below.

2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child

   First Name _____ Last Name _____

3. If the patient is a dependent child, please provide spouse's date of birth: Day | Month

4. Is the other insurance also with Canada Life? ☐ Yes ☐ No*

   If yes, please provide: Canada Life plan number _____ ID Number _____

5. Is treatment required as the result of an accident? ☐ Yes ☐ No

   If yes, what kind of accident? ☐ Motor Vehicle ☐ If other, please explain. _____

6. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

*If the other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach the other insurer Explanation of Benefits (EOB) to this claim. An EOB is required even if no benefits were paid by the other insurance.



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## PART 4 - Patient Information - Complete for all expenses; one line per patient.

| Patient name First name/Last name | Patient's Relationship to plan member Self | Child | Spouse | Patient's Date of birth Day | Month | Year | If child over 18 years: Full time student hours per week | Yes | No | If employed, how many hours worked per week? | Does patient reside with Plan Member? Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | | | | | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | | | | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | | | | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | | | | ☐ | ☐ | | ☐ | ☐ |

## PART 5 - Claim Details - If additional space is needed, attach a separate page.

| Patient Name - First name/Last name | Type of Expense | Nature of Illness |
|---|---|---|
| | | |
| | | |
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| | | |

## PART 6 - Prescription Drug Expenses - Credit card receipts and/or debit slips alone are insufficient. Official pharmacy or clinic/physician receipts are required.

All receipts must include:
- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

Please note, receipts for drugs dispensed in Ontario must include the dispense fee.

## PART 7 - Paramedical Expenses - For chiropractor, physiotherapist, massage therapist, psychologist, etc.

All receipts must include:
- Patient name
- Date of service
- Name of treatment provided
- Charge for each service
- Provider's name, address, telephone number, professional designation and professional association
- Amount paid by provincial plan if applicable

## PART 8 - Medical Expenses - For medical equipment, appliances and services.

All receipts must include:
- Patient name
- Date item was received
- Name of item purchased or a detailed description of the services or supplies
- Charge for each item/service
- Provider's name, address, telephone number and professional designation
- Amount paid by provincial plan if applicable

## PART 9 - Visioncare Expenses - Laser eye surgery, glasses, contact lenses and eye exams.

**Receipt details**

All receipts must include:
- Patient name
- A breakdown of charges for lenses & frames or eye exam
- Date eyewear was received
- Date the eye exam was performed and paid for

| Patient Name First name/Last name | Reason for purchase of lenses (check all that apply) Initial prescription | Prescription change | Loss or breakage | None of these reasons |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ |

## PART 10 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below.

**Questions? Call Toll Free: 1 855 644-0538**

Winnipeg Benefit Payment Office
PO Box 6040, Station Main
Winnipeg MB R3C 0S2
Canada
www.canadalife.com

**Deaf or hard of hearing and require access to a telecommunications relay service?**
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511

Clear