Please complete Schedule A and Schedule B (attached) and return these to Canada Life as soon as possible to ensure prompt assessment of your claim. These forms will be returned to the claimant if not fully completed.

Schedule “A”

ASSIGNMENT OF PAYMENT DUE TO BENEFICIARY UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN: ____
(patient name) (of the first part hereinafter referred to the Assignor)

AND: THE CANADA LIFE ASSURANCE COMPANY
(of the second part hereinafter referred to as the Assignee)

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF SASKATCHEWAN AS REPRESENTED BY THE MINISTER OF HEALTH
(Hereinafter referred to as the Minister)

WHEREAS the Assignor is a person eligible for medical services under the Saskatchewan Medical Care Insurance Act or the Saskatchewan Hospitalization Act or both, and as such may receive payment for the above services from the Minister.

And WHEREAS the Assignor is under a covenant of obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the assignor, his heirs, executors, or administrator.

DATED this ____________________ *day of* ____________ *year* ________

Signature of Assignor ______________________________________

WITNESS Signature ____________________ *Occupation* ____________________

ASSIGNMENT Effective From ____/____/____ *TO* ____/____/____
(First Date of Claim to Last Date) *Month Day Year* *Month Day Year*

Canada Life Plan Number/Employer __________ *Certificate or I.D. Number* __________

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Schedule “B”

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, ____
(patient name)

(OR I ____
(if insured is a minor dependent)

Parent/Guardian of ____ *a minor)*

hereby consent to and authorize the Department of Health to furnish to any representative of The Canada Life Assurance Company, claim and payment information in the Department of Health’s possession in respect of claims for Medical Services incurred while I had insurance coverage from ______________ (First Date of Claim), and may include payment and claim information for the period within 6 months prior to the date of service of the aforementioned Medical Services including physician/hospital name, date of service, and service provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory service).

DATED this ________________________ *day of* __________________ *year* __________

Patient’s Health Services Number: ______________________________________

Signature: ____

Address: ____
____
____
____
____
____
____

Telephone Number: ____