

MEDICAL REIMBURSEMENT PLAN EXPENSE STATEMENT

	Benefit to be paid: \Box Healthcare/Vision \Box Dentalcare \Box Both										
Important Information											
An expense is eligible for reimbursement under the Medical Reimbursement Plan if:											
 it qualifies under the <i>Income Tax Act</i> (Canada) for the purpose of calculating the medical expense credit, and it is either not covered or only partially covered by another public or private health insurance plan. 											
If The Canada Life Assurance Company (Canada Life) determines that a particular expense is not an eligible expense, the plan member may wish to obtain independent professional tax advice or contact the Canada Revenue Agency for a formal opinion. Further information may be obtained by visiting the Canada Revenue Agency website at www.cra.gc.ca or contacting the Canada Revenue Agency by telephone.											
Instruct	tions for Claim Submission										
Please:											
1.	Complete this form in full.										
2.	2. Keep a photocopy of this form and your receipts.										
3.	 3. Staple together and submit: • this original form • all supporting receipts and invoices, including the other insurer's Explanation of Benefits, if applicable 										
Note: This form must be signed by the plan member.											
Part 1:	Plan Member Information										
Group Pl	lan Number Plan Member Identification Number										
Plan Member Name											
Address:	Number and Street Town Province Postal Code										
all good	that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify the sand services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and ents are eligible under the terms of my plan.	nat nd/or									
I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).											
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.											
	onsent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purpo										
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 .											
Plan Mer	mber Signature										
Date											

If yes, name of family member insurance	Part 2: Dependent Information																
Patient Name Number of Number of Receipts Number of Number of Receipts Number of Receipts Number of Number o																	
Part 3: Coordination of Benefits Are you or any other member of your family entitled to benefits under any other plan? Yes No Por week? Yes No per week? Yes No per week? Yes No per week? Yes No Por week? Yes No Yes No Por week? Yes No Yes No Por week? Yes No Yes N	Patient Name	1		D	ate o	of Birth	f Birth		reside with you?				Empl	oyed?			
Part 3: Coordination of Benefits Are you or any other member of your family entitled to benefits under any other plan?	r alloni riamo	to Er	nployee	Year			Month	Day						YES	NO		
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Are you or any other member of your family entitled to benefits under any other plan? Yes No If yes, name of family member insured Relationship to employee Policy Number Sam of other insurance company Policy (Number Sam of other insurance company Policy (Number Sam of other han yourself) insured as an employee under this plan? Yes No If yes, name of family member If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: Noter Note Note																	
If yes, name of family member insured	Part 3: Coordination of Benefits																
Name of other insurance company Is any member of your family (other than yourself) insured as an employee under this plan? Yes No If yes, hare of family member If yes, the either question above, and the patient is a dependent child, please provide spouse's date of birth: New No If yes, great of family member If yes, the either question above, and the patient is a dependent child, please provide spouse's date of birth: New No If yes, great date, location and explain how accident happened Is a claim being made for Worker's Compensation Benefits? Yes No If yes, give date, location and explain how accident happened Is a claim being made for Worker's Compensation Benefits? Yes No If yes, give date, location and explain how accident happened Is a claim being made for Worker's Compensation Benefits? Yes No If yes, give date, location and explain how accident happened Is a claim being made for Worker's Compensation Benefits? Yes No If yes, great No If yes, give date, location and explain how accident happened Is a claim being made for Worker's Compensation Benefits? Yes No If yes, great No If yes No If yes, great No If	Are you or any other member of your family entitled to benefits under any other plan?																
Name of other insurance company Is any member of your family (other than yourself) insured as an employee under this plan? Yes No If yes, hare of family member If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth:	If yes, name of family member insured																
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If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth:	Is any member of your family (other th	han yoursel	f) insured as a	ın en	nplo	oyee	unde	r this p	olan?	Yes [No						
Is treatment required as the result of an accident?	If yes, name of family member																
Is treatment required as the result of an accident?	If yes, to either question above, and the	he patient	is a dependen	t chi	ld,	plea	se pro	vide s	pouse's	date of b	oirth:	7.7	_///		_		
Patient Name Number of Receipts Type of Expense Nature of Illness Total Charge	(Year / Month / Day) Is treatment required as the result of an accident? Yes No If yes, give date, location and explain how accident happened																
Patient Name Number of Receipts Type of Expense Nature of Illness Total Charge																	
Patient Name Number of Receipts Type of Expense Nature of Illness Total Charge	Is a claim being made for Worker's Compensation Benefits?																
Expenses Submitted to Canada Life Number of Receipts Number of Receipts Number of Receipts Total Charge Reimbursement in amounts of \$10.00 or less will be processed at your next claim submission and included with your next payment. Please send your Medical Reimbursement Plan Expense Statement to the benefit payment office that processes all of your health and dental claims. If you are unsure of the correct benefit payment office, please contact your plan administrator. The Canada Life Assurance Company PO Box 4408 Regina SK S4P 3W7 The Canada Life Assurance Company PO Box 5160 Station B London ON N6A 0C6 The Canada Life Assurance Company Place Bonaventure 800 de la Gauchetière Street W Suite 5800 Montreal QC H5A 1B9 The Canada Life Assurance Company Please contact us: TTY to Voice: 711	Part 4: Claim Details																
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