MEDICAL REIMBURSEMENT PLAN EXPENSE STATEMENT

Benefit to be paid: ☐ Healthcare/Vision ☐ Dentalcare ☐ Both

Important Information

An expense is eligible for reimbursement under the Medical Reimbursement Plan if:

- it qualifies under the *Income Tax Act* (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 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.

Instructions for Claim Submission

Please:

1. *Complete this form in full.*
2. *Keep a photocopy of this form and your receipts.*
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 and group contractholder.*

Part 1: Plan Member Information

Group Plan Number _____ Plan Member Identification Number _____

Plan Member Name _____

_____

Address: Number and Street Town Province Postal Code

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.

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.

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.

Plan Member Signature _____

Date _____

Turn over for side 2

Part 2: Dependent Information

Patient Name	Relationship to Employee	Date of Birth Year	Month	Day	Does patient reside with you? YES	NO	Full-Time Student? YES	NO	If child over 18 years: If student, how many hours per week?	Employed? YES	NO	How many hours worked per week?
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	

Part 3: Coordination of Benefits

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 _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than 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: _____ / _____ / _____ (Year / Month / Day)

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 Worker's Compensation Benefits? ☐ Yes ☐ No

Part 4: Claim Details

Patient Name	Number of Receipts	Type of Expense	Nature of Illness	Total Charge

Expenses Submitted to Canada Life 0 (Number of Receipts) $ $ 0.00 (Total Charge)

Reimbursement in amounts of $10.00 or less will be processed at your next claim submission and included with your next payment.

Part 5: Group Contract Holder Information

I, the undersigned, on behalf of the group contractholder, hereby request that the expenses outlined above be reimbursed.

Company Name: _____ [insert full legal name of group contractholder]

Signature: _____

Name: _____

Title: _____

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.

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Regina SK S4P 3W7

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London ON N6A 0C6

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Montreal QC H5A 1B9

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PO Box 3050 Station Main
Winnipeg MB R3C 0E6

The Canada Life Assurance Company
Out-of-Country Claims
PO Box 6000
Winnipeg MB R3C 3A5

www.canadalife.com

Questions? Call Toll Free: 1 877 883-7072

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