

## **Group Benefits Extended Health Care Claim**

To be completed by the plan member unless otherwise indicated. Original receipts must be provided for all expenses. Please retain copies for your files as original receipts will not be returned.

| _   |   |  |                      |                   |                             |  |                 |  |
|-----|---|--|----------------------|-------------------|-----------------------------|--|-----------------|--|
| 1   | Plan member information   | Plan contract number   |                      | Plan me           | mber certificate number     | -  |                 |  |
|     |   | Plan sponsor   |                      |                   |                             |  |                 |  |
|     |   | Plan member name (first, middle initial, last)   |                      |                   |                             |  |                 |  |
|     |   | Date of birth (dd/mmm/yyyy)  |                      |                   | Daytime phone num           | ber  |                 |  |
|     |   | Plan member address (numbe   | r, street and apt.)  |                   |                             |  |                 |  |
|     |   | City/Town  |                      | _ Province        |                             | Postal code                                      |                 |  |
| 2   | Workers'  | Are any of the expenses associ   | ciated with a work   | related incident  | AND eligible for workers    | c' compensation benefits? Ye                     | es O No         |  |
|     | compensation board  | If yes, submit these expenses to your provincial workers' compensation board.  |                      |                   |                             |  |                 |  |
| 3   | Coordination  | Are you, your spouse or deper  | ndants covered un    | der any other pla | n for the expenses beir     | ng claimed? Yes No                               |                 |  |
|     | of benefits   | 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:  |                      |                   |                             |  |                 |  |
| Sp  | ouse's date of birth (  | dd/mmm/yyyy)   | Name                 | of spouse's insu  | rance company               |  |                 |  |
| Sp  | ouse's plan contract  | number   |                      |                   | Spouse's plan member        | certificate number                               |                 |  |
| lf  | Manulife is your seco   | ndary carrier, include copies of   | the receipts and th  | ne explanation of | benefits from your prim     | nary carrier.                                    |                 |  |
| 4   | Patient information   | Patient's name   | (do                  | Date of birth     | Relationship to plan member | Complete if patient is a student School and city | : 18 or older.  |  |
|     | Complete for all expenses. Use one line per patient.  |  |                      | st Claim only)    | (1st Claim only)            | ·  | worked per week |  |
|     |   |  |                      |                   |                             |  |                 |  |
|     |   |  |                      |                   |                             |  |                 |  |
| 5   | Prescription drug expenses  | Include your prescription di     All receipts must contain th     You are not required to list   | e drug identificatio | n number (DIN)    | and the name of the pre     | escription drug.                                 |                 |  |
| 6   | Practitioner/<br>Paramedical<br>expenses<br>(e.g. chiropractor,<br>massage therapist,<br>physiotherapist, etc.) | For practitioner/paramedical expenses please include an <b>itemized statement</b> and/or receipt stating:  |                      |                   |                             |  |                 |  |
|     |   | <ul> <li>patient name,</li> <li>date of service,</li> <li>name of practitioner,</li> <li>type of practitioner,</li> <li>date last paid by provincial plan (if applicable) and</li> <li>licence and/or registration number.</li> <li>charge for treatment,</li> </ul> |                      |                   |                             |  |                 |  |
|     |   | If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.  |                      |                   |                             |  |                 |  |
| 7   | Equipment and appliance expenses  | For equipment and appliance of and a copy of the provincial plandicate the activities requiring the  | an statement of pa   |                   |                             | n the prescribing physician, includ              | ing diagnosis,  |  |
|     |   |  |                      |                   |                             |  |                 |  |
| ים  | ıration equinment is r  | equired: <b>From:</b> Date (dd/mmm/  | www)                 |                   | <b>To:</b> Date (dd/m       | ımm/yyyy)  |                 |  |
|     | as rental equipment b   |  |                      |                   | io. Date (dd/iii            |  |                 |  |
| 110 | io remai equipinient D  | confetument tes  | INU                  |                   |                             |  |                 |  |

Please complete next page.

| 8 Vision care expenses  • patient name, - cost of laser surgery, - date of eye exam, - cost of contact lenses, - dispensing fee, - cost of the laser surgery, - cost of contact lenses, - cost of eye exam, - cost of thining, - cost of contact lenses, - cost of eye exam, - cost of thining, - cost of contact lenses prescribed for severe cornect lenses, please answer the questions below:  Were contact clenses prescribed for severe cornect lenses, please answer the questions below:  Were contact lenses prescribed for severe cornect adaptmatism, keratocornus or aphabatar - conditions and conditions the improved by at least 2 Elvies on the Stretch chart over the beet possible vision with glasses?  Signature of supplier  9 Banking 9 Banking 9 Complete only when providing not contact the conditions and conditions are conditions and conditions and conditions are conditions and conditions and conditions are conditions and conditions are conditions and conditions and conditions are conditionally and conditional and conditions are conditionally and conditions are co           |   |  |   |   |  |   |  |  |  |
|--|---|--|---|---|--|---|--|--|--|
| TO BE COMPLETED BY SUPPLIER  If your contract covers medically necessary contact lenses, please answer the questions below:  Were contact lenses prescribed for severe corneal astigmatism, keratocorus or aphakia?  Can visual acuty be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses?  Yes No Could visual acuty be improved up to at least the 2040 level by glasses?  Signature of supplier  Date signed (dotminmy/yyyy)  Visit manualife.ca/planmember to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile men UPC complete this section  information and email address  Visit manualife.ca/planmember to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile men UPC complete this section.  Complete sort public of the providing your banking information on your personal cheque or bank.  Complete only when providing your banking information on your personal cheque or bank.  Transit number  Transit number or section of the providing a link.  Member secure site.  Email address (Please print clearly)  Total amount of ALL receipts  submitted  Total amount of ALL receipts  submitted  Total amount of ALL receipts  submitted submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. <u>Lunderstand and acknowledge</u> that submission of a claim determined by Manufile to be false or misrepresented will be actermined where falsely submitted to see enforcement submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. <u>Lunderstand and acknowledge</u> that submission in fall and my monies or overpayments that I may owe to Manufile in a consorting that the provisions of the Group Benef | 8   | 1101011 0010   | <ul><li>patient name,</li><li>cost of contact lenses,</li></ul>   | <ul><li>cost of laser surgery,</li><li>dispensing fee,</li></ul>  | <ul> <li>cost of tinting,</li> </ul>   |   |  |  |  |
| If your contract covers medically necessary contact lones, please answer the questions below:  |   |  | cost of glasses,  | cost of eye exam,   | date dispensed.  |   |  |  |  |
| Were contact lenses prescribed for severe comeal astignatism, keratocorus or aphabia?  Can visual acuity be improved by at least 2 lines on the Snellen And over the best possible vision with glasses?  Yes No  Signature of supplier  Date signed (addimnmy)yny)  Banking information and email address  Visit manuffic ca/planmember to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile menu OR complete this section.  Complete only when providing new or providing new or providing new or up of the providing new or present cheeped or bank statements under the My Profile menu OR complete this section.  By providing your banking information on your present cheeped or bank statements. The providing new or present cheeped or bank statements are discontinued, visit manuffic a. Appear you present cheeped or bank statements. The providing new or present cheeped or bank statements. The providing new or present cheeped or bank statements are discontinued, visit manuffic adaptaments or new your electronic claim statements. The provided for all expenses.  10 Claims  Confirmation  Total amount of ALL receipts  Submitting a claim to Manuffe, 1 confirm that 1 understant and agree to all of the following:  Learning the provided for all expenses.  11 Authorization and consent  By submitting a claim to Manuffe, 1 confirm that 1 understant and agree to all of the following:  Learning the provided for all expenses.  12 Authorization and consents  13 Lauthorization and consents  14 Lauthorization and consents  15 Lauthorization and consents  16 Lauthorization and consents  17 Lauthorization and consents  18 yeurophy the provided for all expenses and complete and that 1, my gouse and/or my dependents have received the provided for all expenses           |   | TO BE COMPLETED BY SUPPLIER  |   |   |  |   |  |  |  |
| Banking information and email address  Banking information and email address  Complete only when providing new or updated information.  By providing your banking information and email address your providing new or updated information.  By providing your email address, you will receive an email notification once your claim has been providing new or updated information.  By providing your email address, you will receive an email notification once your claim has been processed, including a link bomaville. Ca. where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements on the email address, you will receive an email notification once your claim has been processed, including a link bomaville. Ca. where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements on the ensure your personal cheepers of the providing of the providing of the providing of the provided for all expenses.  10 Claims Confirmation  Total amount of ALL receipts submitted Systematics. A submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. Lunderstand and acknowledge that submission of a claim telement of by Manuffle to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. Lunderstand plan deciration and exchange this information with each other and with Manuffle. Its resource of the proposes of claims telement of this claim. Information providers, for the purposes of claims to collect, use, maintain and exchange this information with each other and with Manuffle. Its reinsurers and/or its service providers, for the purposes of claims to collect, use, maintain and exchange this information with each other and with Manuffle. Its reinsurers and/or its service providers, for the purposes of claims that administration, audit and the assessment, investigation and management of this claim (Purposes)           |   | Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia?  Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses?  Yes  No  No  |   |   |  |   |  |  |  |
| complete only when providing new or updated information.  Total amount of ALL receipts with manuffic action and consent Sy submitting a claim to Manuffic in the claim statements when the complete only when providing new or updated information.  Total amount of ALL receipts Submitting a claim to Manuffic in the claim statements are descontinued, visit manuffic.caplanmember to register for your Flan Manuffic and the statement or contact your branch.  Total amount of ALL receipts Submitting a claim to Manuffic in the claim statements are descontinued, visit manuffic.caplanmember to register for your Flan Manuffic in the information of the claim (s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all godos or services as calienad. Understand and acknowledge that submission of a claim determined by Manuffic to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. I understand and acknowledge that submission in claim providers, professional regulatory bodies, any employer, group plan administration, and into the submission. Lauthorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administration, and and exchange this information with miscromation, its remiscressional regulatory bodies, any employer, group plan administration, and my further claims. Jauthorize the use of my Social proposes of identification and exchange this information with miscromation, its remiscress and claims of the proposes of forcup Benefits plan administration, and and the assessment, investigation and management of this claim (purposes). Laugage that my coverage may be denied or further than the miscromatic propages of identification and administration, and that have identified on this form. Longriffied the number. Lauthorize the unification with proposes) Laggage that they oppose of identification           |   | ,  | ·   | , ,   | Date signed  |   |  |  |  |
| complete mail address    Complete only when providing new or updated information.   Supproviding your banking information.   Supproviding new or updated information.   Supproviding new or updated information.   Supproviding your email address, you will receive an email notification once your claim has been processed, including a link to manuffic.ca, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements. To ensure you can view your electronic claim statements. To ensure you can view your electronic claim statements. To ensure you can view your electronic claim statements. To ensure you can view your electronic claim statements. To ensure you can view your electronic claim statements are discontinued, visit manuffic.ca/plammenber to register for your Plan  | _   | Daniel de la   | Visit manulifo ca/planmombe   | ar to register and sign in to your  | Plan Member secure site. Then si   | an up for direct deposit and electronic   |  |  |  |
| By providing your banking information on claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.  By providing new or updated information.  By providing your email address, you will receive an email notification once your claim has been processed, including a link tor manuific ca, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit manuific.ca/planmember to register for your Plan Member secure site.  Email address (Please print clearly)  10 Claims confirmation  Total amount of ALL receipts submitted submitted by the provided for all expenses.  11 Authorization and consent  By submitting a claim to Manuilfe, I confirm that I understand and agree to all of the following:  Learly that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. Lunderstand and acknowledge that submission of a claim determined by Manuilfe to be false or misrepresented will be reprovided, by the claim of the control of the           | 9   | Banking information and  | VISIT Manume.ca/planmembe   | claim statements under the My   | Profile menu OR complete this se   | ection.   |  |  |  |
| Complete only when providing new or updated information.  Total amount of ALL receipts  when the providing and the providing to the providing t           |   |  | information, your claim pays<br>be deposited directly to you  | ments will " 108" 1:011 r account.  | 22" 540" 000 1 1 " 0 "   | •   |  |  |  |
| or updated information.  Total amount of ALL receipts   Total            |   | only when  | on your personal cheque or  | bank Transit numbe  | Institution number Accoun  | it number   |  |  |  |
| Total amount of ALL receipts submitted \$ NOTE - ORIGINAL RECEIPTS must be provided for all expenses.  11 Authorization and consent  By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:  Lertify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. I understand and acknowledge that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. I understand and acknowledge that Manulife may refer any claims It has determined where falsely submission. 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, investigation and administrator 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 of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). Lagree that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.  Lagree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and Lauthorize Manulife to deduct such nonies from my future claims. Lauthorize the use of my Social Insurance Number ("SIN") for the purposes of identification and daministration, if my SIN is used as my plan member certificate number, Lagree a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. Lunderstand that Manulife's Privacy Policy is available at manulife cagroup benefits, or from my Plan Sponsor.  If applicable, Lauthorize Manulife to deposi          |   | providing new or updated   | to manulife.ca, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit manulife.ca/planmember to register for your Plan   |   |  |   |  |  |  |
| 10 Claims confirmation  Total amount of ALL receipts submitted  NOTE - ORIGINAL RECEIPTS must be provided for all expenses.  11 Authorization and consent  By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:  Lertify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. Lunderstand and acknowledge that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. Lunderstand and acknowledge that Manulife may refer any claims it has determined where falsely submitted to law enforcement authorities for possible prosecution. Manulife plursus the recovery of any money that has been obtained improperly through false claim submission. Lauthorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigation and aministrator insurers and/or its service providers, for the purposes of Coroup Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). Lagree that my coverage may be denied or terminated because of my providing false, incomplete or misleading information.  Lagree to retund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and Lauthorize Manulife to deduct such monies from my future claims. Lauthorize when the celectronic version of this authorization and administration, if my SiN is used as my plan member certificate number. Lagree a photocopy, facisimal or electronic version of this authorization shall be as valid as the original. Lunderstand that Manulife's Privacy Policy is available at manulife, cagroup benefits, or from my Plan Sponsor.  If applicable           |   |  |   | rint clearly)   |  |   |  |  |  |
| The provided for all expenses.  11 Authorization and consent  By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:  Lectrify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. Lunderstand and acknowledge that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. Lunderstand and acknowledge that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Multife will pursue the recovery of any money that has been obtained improperly through false claim submission. Lauthorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administratior, insurer, investigation 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 of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). Lauree that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.  Lagree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and Lauthorize Manulife to deduct such monies from my future claims. Lauthorize 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. Lagree a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. Lunderstand that Manulife's Privacy Policy is ava           |   |  |   |   |  |   |  |  |  |
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| <u>I understand</u> that if I do not wish to receive emails from Manulife, I can unsubscribe, remove my email address online or contact the Customer Service Centre at 1-800-268-6195 to have my email address removed. <u>I understand</u> that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:  | By Lc all rep de improto Be ter La and the by If a is i | r submitting a claim to ertify that the information goods or services as claim to good the good of the | Manulife, I confirm that I und on provided for the claim(s) beir aimed. I understand and ackn y related information/documenta ubmitted to law enforcement autilaim submission. I authorize argulatory bodies, any employer, ond exchange this Information witten, audit and the assessment, ir providing false, incomplete or ries or overpayments that I may duct such monies from my futur SIN is used as my plan member erstand that Manulife's Privacy Manulife to deposit all payments ntified on this form. I confirm the choose to name in the future are that upon the deposit of any Paystand and agree that Manulife in written endorsement relating to finot entitled, either by contract or resentatives or by representative | ng submitted is true, accurate a owledge that submission of a cation, to my plan sponsor. I under thorities for possible prosecution by person or organization with largroup plan administrator, insured the each other and with Manulife the each other and with Manulife the estigation and management of the each other and with Manulife the estigation and management of the each insulation.  Owe to Manulife in accordance reclaims. I authorize the use of certificate number. I agree a plant policy is available at manulife. I due to me from the above-referent this direct bank deposit authorize this direct bank deposit authorize this direct bank deposit authorize man, at any time and without produture Payment(s). I also herebor by law, shall not form part of the soft my estate. | and complete and that I, my spoused aim determined by Manulife to be erstand and acknowledge that I in. Manulife will pursue the recoverance in incompation, including any medical right in investigative agency, and any area, its reinsurers and/or its service point its claim (Purposes). I agree the with the provisions of the Group I in its financial I investigative agency from my Plan renced Group Benefits Plan ("Payorization applies to the financial ir ed in writing by me or by my duly ulife is fully discharged from any fuor notice, discontinue the direct of y acknowledge and agree that in the result in the service is the service of the service in the direct of y acknowledge and agree that its results in the service is the service in the service in the service in the service is the service in the service in the service in the service is the service in the service in the service in the service is the service in the service in the service in the service is the service in the service in the service in the service is the service in the service in the service in the service in the service is the service in the service in the service in the service is the service in the service in the service in the service in the service is the service in the service i | e false or misrepresented will be Manulife may refer any claims it has ery of any money that has been obtained and health professionals, facilities or dministrators of other benefits programs providers, for the purposes of Group nat my coverage may be denied or Benefits plan with Manulife, and SIN") for the purposes of identification tersion of this authorization shall be as a Sponsor.  In Sponsor of the bank account nestitution herein named by me and any authorized representative. Lurther liability with respect to such leposit of Payment(s) requested herein any Payment(s) made by Manulife into |  |  |  |
| my Information will be limited to:   | au  | ioi aaiiiagoo v  |   |   |  |   |  |  |  |
|  | <u>l u</u><br>1-8                                       | inderstand that if I do n<br>800-268-6195 to have n  | which I may incur as a result of in<br>should the email address idention<br>ot wish to receive emails from Normal address removed.  | nterception by a third party of a<br>fied on this form change, I am I<br>Manulife, I can unsubscribe, ren   | n email transmission sent by Man<br>esponsible for updating the email<br>love my email address online or c   | ulife or by me pursuant to this<br>address maintained by Manulife.<br>contact the Customer Service Centre at  |  |  |  |

- persons to whom I have granted access; and
   persons authorized by law.

<u>I have the right</u> to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

## **PLEASE SIGN HERE**

| Signature of plan member   | Da | ate signed (dd/mmm/vvvv)      |
|----------------------------|----|-------------------------------|
| olgitatare of plant member |    | 10 Signed (dd/illillill/yyyy) |

## 12 Mailing instructions

Please mail your completed claim form and receipts to:

**Manulife Group Benefits Health Claims** PO BOX 2580, STN B MONTREAL QC H3B 5C6