Manulife

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 119848 Plan member certificate number _____

Plan sponsor Millwrights' Health & Welfare Trust Fund For Alberta

Plan member name (first, middle initial, last) _____

Date of birth (dd/mmm/yyyy) _____ Daytime phone number ( ) _____

Plan member address (number, street and apt.) _____

City/Town _____ Province _____ Postal code _____

2 Workers' compensation board

Are any of the expenses associated with a work related incident AND eligible for workers' compensation benefits? ◯ Yes ◯ No

If *yes*, submit these expenses to your provincial workers' compensation board.

3 Coordination of benefits

Are you, your spouse or dependants covered under any other plan for the expenses being claimed? ◯ Yes ◯ No

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:

Spouse's date of birth (dd/mmm/yyyy) _____ Name of spouse's insurance company _____

Spouse's plan contract number _____ Spouse's plan member certificate number _____

If Manulife is your secondary carrier, include copies of the receipts and the explanation of benefits from your primary carrier.

4 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy) (1st Claim only)	Relationship to plan member (1st Claim only)	Complete if patient is a student 18 or older.	
			School and city	If employed, hrs worked per week

5 Prescription drug expenses

- Include your prescription drug receipts with this form.
- All receipts must contain the drug identification number (DIN) and the name of the prescription drug.
- You are not required to list this information on the form.

6 Practitioner/ Paramedical expenses

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please include an **itemized statement** and/or receipt stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

7 Equipment and appliance expenses

For equipment and appliance expenses Manulife requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item.

Duration equipment is required: **From:** Date (dd/mmm/yyyy) _____ **To:** Date (dd/mmm/yyyy) _____

Has rental equipment been returned? ◯ Yes ◯ No

Please complete next page.

8 Vision care expenses

Please enclose an itemized receipt indicating:

- patient name,
- cost of contact lenses,
- cost of glasses,
- cost of laser surgery,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- date dispensed.

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, keratoconus or aphakia? ◯ Yes ◯ No

Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses? ◯ Yes ◯ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯ Yes ◯ No

Signature of supplier _____ Date signed (dd/mmm/yyyy) _____

9 Banking information and email address

Visit **manulife.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.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.

Complete **only** when 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 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 Member secure site.

Email address (Please print clearly)

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:

I certify 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 were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim 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, investigative 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). **I agree** that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

I agree 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 **I authorize** Manulife to deduct such monies from my future claims. **I authorize** 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. **I agree** a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Manulife's Privacy Policy is available at manulife.ca/groupbenefits, or from my Plan Sponsor.

If applicable, **I authorize** Manulife to deposit all payments due to me from the above-referenced Group Benefits Plan ("Payments") into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or by my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s) requested herein and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account to which I am not entitled, either by contract or by law, shall not form part of my property and shall be immediately refunded to Manulife, either by me, by my duly authorized representatives or by representatives of my estate.

If applicable, **I authorize** Manulife to use the email address provided as a means of communication with me related to my group benefits. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** that should the email address identified on this form change, I am responsible for updating the email address maintained by Manulife. **I understand** 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.

I understand 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:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right 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 _____ Date signed (dd/mmm/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

PRINT RESET