

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 member certificate number _____

Plan sponsor _____

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) _____ Spouse's plan member certificate number _____

Name of spouse's insurance company _____ Spouse's plan contract number _____

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

4 HCSA contract number

Check here to use your Health Care Spending Account (HCSA) to reimburse any unpaid portion of this claim.
(If the patient has health coverage under another plan, you **must** submit any unpaid amount from this claim to that plan **before** using your HCSA.)

5 Patient information	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
Complete for all expenses. Use one line per patient.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

6 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.

7 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.

8 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

