Manulife

VICTOR

Group Benefits and Retirement Solutions
Extended Health Care Claim

To be completed by the plan member unless otherwise indicated.
Original receipts must be attached for all expenses. (Please attach to the back of this form.)
Please retain copies for your files as original receipts will not be returned.

1 Plan member statement

Plan contract number	Plan member certificate number	Plan sponsor
98596		**Victor Insurance Managers Inc.**

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)
Address (number, street and apt.)	**City/Town**

Province	Postal code	Telephone number
		( )

Are these expenses eligible for coverage under any type of workers' compensation board?
◯ Yes ◯ No

Are you or your spouse 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 number	Spouse's certificate number

Sign up for the Plan Member Secure Site today!

The **Plan Member Secure Site** gives you easy access to all your plan information including the following:

- The ability to receive your claims payments up to **80%** faster with Direct Deposit
- Submit your claim online or through our Group Benefits Mobile App without completing and mailing in a paper claim form
- Electronic Claims Statements and the ability to view detailed historic information
- Information on Provider eClaims*, a convenient way for your health care providers to submit claims for you, visit **manulife.ca/planmember/providereclaims**

Visit **manulife.ca/planmember** today to take advantage of our self-serve and online features.
All your benefit information is just a click away!

2 Patient information

Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy)	Amount of expense
◯ Retiree ◯ Spouse		
◯ Retiree ◯ Spouse		

3 Prescription drug expenses

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

4 Practitioner/ Paramedical expenses

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

For practitioner/paramedical expenses please attach an **itemized 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.

5 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.

6 Vision care expenses

Please enclose an original itemized receipt issued by a supplier indicating:

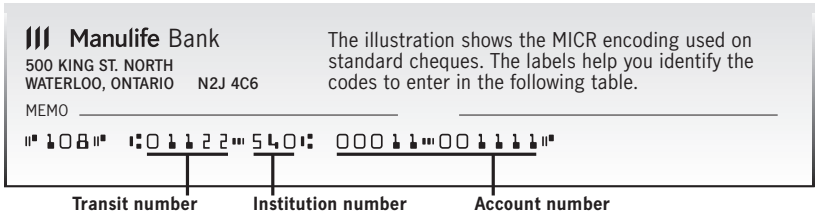
- patient's name,
- cost of contact lenses,
- date dispensed.
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- treatment,

7 Banking information for direct deposit

NOTE - If you currently have direct deposit with Manulife, you are not required to complete this section.

To have this and all future claim payments deposited directly into your bank account, attach a void cheque to this claim form and indicate *Yes*, in the box below.

◯ Yes, I have attached a void cheque **or** completed the section below and would like all my future claim payments deposited into this account.



Name of bank or financial institution	Transit number	Institution number	Account number

8 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted $

I certify that I, and/or my spouse have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** The Manufacturers Life Insurance Company (Manulife) to collect, use, maintain, and disclose personal information relevant to this claim ("Information") for the purposes of plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, 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. If applicable, **I authorize** Manulife to deposit all payments ("Payments") due to me from the above referenced Retiree Benefits policy ("Policy"), 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 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), as 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 or by representatives of my estate. **I agree** a photocopy or electronic version of this authorization is valid.

PRINT

RESET

SAVE AS

Plan member signature	Date signed (dd/mmm/yyyy)

9 Statement of confidentiality

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Retiree Benefits health file. Access to your Information will be limited to:

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

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Institutional, Manulife, PO BOX 1602, Del Stn 500-4-A, Waterloo, ON N2J 4C6. A copy of our privacy principles and practices is available for view at **manulife.ca**.

10 Mailing instructions

Manulife will not assume responsibility for any fees associated with the completion of this form.

Please mail your completed claim form and **original receipts** to the appropriate address.

If you live outside of Quebec:
Manulife Group Benefits and Retirement Solutions
Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1

If you live in Quebec:
Manulife Group Benefits and Retirement Solutions
Health Claims
PO BOX 2580, STATION B
MONTREAL QC H3B 5C6

11 We're here to help!

Should you have any questions on our self service features and claims handling inquiries.

manulife.ca/planmember
Register for the Plan Member Secure Site, and email your inquiries to our Contact Centre.
1-800-268-6195 – Monday to Friday – 8am - 8pm ET

*Provider eClaims is provided by TELUS Health, on behalf of the Manufactures Life Insurance Company (Manulife).