

Instructions: Attach the original bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Receipts will not be returned. Please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes. Claims will not be honoured if received later than the end of the calendar year following the year in which the expense was incurred, or 90 days after the termination of coverage.
Important: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Need more forms? Additional copies of this form are available at: <http://intra.hropenweb.gov.on.ca/pay/main.htm>

A. EMPLOYEE'S STATEMENT Please print or type all information clearly

Indicate the appropriate group: 158879 AMAPCEO 158879 Part-Time

EMPLOYEE IDENTIFICATION NO.	EMPLOYEE'S SURNAME	INITIALS	DATE OF BIRTH	Day	Month	Year
ADDRESS - GIVE NUMBER AND STREET			APT. NO.	TOWN/CITY		PROV.
			POSTAL CODE			

Is treatment required as the result of an accident? No Yes If "Yes", give date, location and how it happened.
 Date of Accident: Month Year Describe Accident Details:

Is a claim being made to the Workplace Safety & Insurance Board (Workers' Compensation)? No Yes

B. COORDINATION OF BENEFITS

NOTE: Charges for dependent children should first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year (excluding the year of birth). Please retain copies of your receipts in case they are needed by a second insurance carrier.

Please complete the following if you or any of your insured dependents are entitled to medical benefits under any other plan, or if your spouse is covered as an employee/retiree under one of the Province of Ontario employees plans.

NAME OF INSURED PERSON	POLICY NUMBER	EMPLOYEE IDENTIFICATION NO.
NAME OF OTHER INSURANCE COMPANY	If the claim is for a dependent child, please provide your spouse's date of birth (excluding year)	
	Day	Month

C. DEPENDENT INFORMATION

Patient Name	Relationship To Employee	Date of Birth Day Mth Year	Answer these if child is over 18 years						
			Does Patient Reside With You?		Full-Time Student?		If Student, how many hours per week?	Employed?	How many hours worked per week?
			Yes	No	Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

D. CLAIM DETAILS

Patient Name	DRUG EXPENSES		OTHER MEDICAL EXPENSES (e.g. Hospital, glasses, physio.)		
	Number of Receipts	Total Charges \$	Type of Expenses	Nature of Illness	Total Charges \$

E. EMPLOYEE DECLARATION IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET

At Great-West 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 Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

SIGNATURE OF EMPLOYEE _____ DATE _____

SEND THIS CLAIM TO

Toronto Benefit Payments
P.O. Box 4076, Station "A"
Toronto, Ontario M5W 3A3

Telephone: 416.440.0406
TOLL FREE: 1.800.874.5899
For the deaf or hard of hearing:
Toll Free: 1.800.990.6654