canada life™

Ontario

Healthcare Expenses Statement
With Healthcare Spending Account

Benefits to be paid from:
- ☐ Healthcare Plan Only
- ☐ Healthcare Spending Account Only
- ☐ Both

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See PART 9.

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 their behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - Plan Member Information (1)

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name: PROVINCE OF ONTARIO - AMAPCEO

Plan number: 158879

Plan member I.D. number:

Plan Member Name

Last name:

First name:

Plan Member Address

Number and street:

City or town:

Province:

Postal code:

Date of birth: Day / Month / Year

Language preference: ☐ English ☐ French

PART 2 - Coordination of benefits (2)

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No If yes, please provide:

Name of insurance company:

Plan number:

Plan member I.D. number:

If spouse's plan, please provide spouse's date of birth: Day / Month / Year

2. Is treatment required as the result of a motor vehicle accident? ☐ Yes ☐ No

3. Is a claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No

PART 3 - Patient information (3)

Complete for all expenses; one line per patient.

Patient name	Relationship to plan member	Date of birth Day	Month	Year	If child over 18 years: Full time student Yes	No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	No
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐
					☐	☐		☐	☐

PART 4 - Prescription drug expenses (4)

For all prescription drug claims

Attach all original receipts.
- Patient name, date of purchase, drug identification number and drug name.

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PART 5 - Paramedical Expenses (5)

For chiropractor, physiotherapist, massage therapist, psychologist, etc.

Attach original receipts. Receipts must indicate the:
- **Patient name, length and type of service and date of service**
- **Healthcare provider's name, address, phone number, designation and professional association**
- **Date last paid by provincial plan (if applicable)**

Provider's name	Type of service	Phone number

PART 6 - Medical Expenses (6)

For medical equipment, appliances and services.

Attach original receipts and recommendation from prescribing physician, including diagnosis.
Receipts must indicate the:
- **Patient name, date of service and description of item purchased**
- **Provider's name, address and telephone number**
- **Provincial plan statement of payment (if applicable)**

PART 7 - Visioncare Expenses (7)

Laser eye surgery, glasses, contact lenses and eye exams.

Attach original receipts.
Reason for purchase of lenses? (check all that apply)

- ☐ **Initial prescription**
- ☐ **Prescription change**
- ☐ **Loss or breakage**
- ☐ **None of the above**

PART 8 - Confirmation, Authorization and Signature (8)

I certify that the information that I have provided on this claim form is true, accurate and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible for benefits coverage under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of false or misrepresented claims seriously. I understand and acknowledge that:

- Canada Life may reassess my claim(s) being submitted at any time including but not limited to, any circumstance where the information on a receipt differs from my claim(s) being made;
- my submission of any claim(s) investigated and determined by Canada Life to be false or misrepresented will be reported, together with any relevant information including evidence resulting from the investigation, to my plan sponsor and/or my employer, including its agents, and the appropriate law enforcement agency;
- Canada Life will pursue the recovery of any money that has been obtained improperly through false or incorrect claim submission.

What could happen if I submit a false or misrepresented claim?

- You could lose your benefits. In addition to having to pay the money back, you could lose your benefits completely
- You could go to jail. Being convicted of fraud results in a criminal record – making it difficult to get a job or travel
- You could lose your job. After all, stealing from your employer is a serious offence, and many employers have a zero-tolerance policy for benefits fraud. Being fired for benefits fraud could also impact your chances of being employed in the future.

At Canada 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 Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for purposes of the administration of my benefits. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member signature X ____________________

Date: Day ______ Month ______ Year ______

PART 9 - Submitting Your Claim (9)

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free: 1.800.874.5899

London Benefit Payments
PO Box 5111 Station B
London ON N6A 0C5

www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511