Manulife

Ontario

Benefits to be paid from:

- ◯ Supplementary Health and Hospital Plan (SHH) only
- ◯ Health Care Spending Account only (134065)
- ◯ Both (first use SHH plan, then use the HCSA to pay any unpaid portion)

Group Benefits
Supplementary Health & Hospital (SHH) Insurance and Health Care Spending Account (HCSA) Claims
Province of Ontario Employee's Plan for OPSEU Unified Members

1. *Use this claim form if you are claiming for an eligible health expense not covered under any other plan, or for which you received partial reimbursement under another plan. Please ensure that you enclose copies of receipts and all insurance carrier's claim statement(s)/explanation of benefit form(s) if applicable, with this claim form.*
2. *Drug receipts filed using this claim process must show either the name of the drug or the Drug Identification Number **(DIN)**.*
3. *Claims incurred under the SHH plan will NOT be honoured later than the end of the calendar year following the year in which the expense was incurred. Claims under the HCSA for expenses incurred in a calendar year (i.e., by December 31st) must be received by the Manulife claims office by May 31st of the following calendar year. The deadline for submission of HCSA claims is different than the usual claims deadline for other SHH and Dental expenses. If you terminate coverage due to resignation, transfer out of OPSEU Unified, retirement or death, claims must be submitted within **90 days of date of termination**. Termination of coverage also applies to Seasonal employees and employees who are on an approved and unpaid leave of absence and who do not elect to pay benefit premiums.*
4. *If you are unsure about coverage for a particular expense, please call Manulife directly at **1-800-268-6195**.*
   *TTY: Teletype Users for the Hearing Impaired **1-800-268-9242**.*

Please retain copies for your own records as original receipts will not be returned.

1 Employee information

Plan number	WIN ID number	Plan sponsor
15900		Province of Ontario

Employee name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Employee address (number, street and apt.)	City or town	Province	Postal code

Mailing address, if different (number, street, and apt., department name and floor)	City or town	Province	Postal code

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 (mm/dd)	Spouse's name (first, middle initial, last)

Name of spouse's insurance company	Spouse's certificate number	Spouse's plan number

Please provide additional accident details on a separate sheet if insufficient space available.

Are any expenses incurred as a result of an accident? ◯ Yes ◯ No If *yes,* specify:

Date of accident (dd/mmm/yyyy)	Patient's name	Details

2 Patient and claim information

Complete for all expenses. Use one line per patient.
Attach list if insufficient space available.

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to employee	Drugs	Other medical expenses e.g. eye glasses, hearing aids, chiropractor, orthotics	Disabled dependant? Yes	Disabled dependant? No	If age 21 or over, full-time student? Yes	If age 21 or over, full-time student? No
					◯	◯	◯	◯
					◯	◯	◯	◯
					◯	◯	◯	◯
					◯	◯	◯	◯

3 Claims confirmation

Total amount of ALL receipts submitted $ _____

NOTE - ORIGINAL RECEIPTS must be provided for all expenses.

4 Banking information and email address

Complete **only** when providing new or updated information.

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.

Transit number | Institution number | Account number

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)

5 Employee authorization and declaration

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods and/or services claimed herein and that the information provided for the claim(s) being submitted is true, accurate and complete. Where the Manufacturers Life Insurance Company (Manulife) at any time determines that the information submitted in support of a claim is incorrect, **I understand and acknowledge** that the claim will be reassessed and that any overpayment will be recovered by Manulife.
I authorize Manulife to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, suggesting health resources and audit and the assessment, investigation and management of my Manulife claims ("Purposes").
I am authorized by my Dependants to disclose and receive their Information, for the Purposes. **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. **I agree** that a claim and/or my coverage and/or my Dependants coverage may be denied or terminated as a result of my providing false, incomplete or misleading Information. **I agree** to refund any monies or overpayments owing to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and **I authorize** Manulife to deduct such monies from future claims. **I understand** that the submission of fraudulent claims is a criminal offence. **I authorize** Manulife to release any relevant information including evidence resulting from the investigation of my submission of any claim(s) determined by Manulife to be false or misrepresented to my plan sponsor and/or my employer, including its agents and the appropriate law enforcement agency. **I authorize** the use of my WIN ID number for the purposes of identification and administration, if my WIN is used as my plan member certificate number.
I agree that 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/planmember, 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.

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.

RESET

A message from your Employer

I understand and acknowledge that further to the terms and conditions outlined, my submission of a false or misrepresented claim may result in disciplinary action, including but not limited to termination of my employment.

By signing below, you are deemed to have read, understood and agreed to the message from your employer.

PLEASE SIGN HERE

Signature of plan member	Date signed (dd/mmm/yyyy)

6 Mailing instructions

Please mail your completed claim form and receipts to the address shown.

Manulife Group Benefits
Health Claims
PO BOX 1657
WATERLOO ON N2J 4W5

1-800-268-6195
TTY: 1-800-268-9242