ASSURE CARD CLAIM FORM

THE Great-West Life ASSURANCE COMPANY

Part 1 – EMPLOYEE INFORMATION – This section MUST be completed in full by the employee.

Employer Name: **PEEL ELEMENTARY TEACHERS' LOCAL**

Employee Name: _____

Employee Address: _____
Box No./Apt. No., Number and Street

_____ City or Town _____ Province _____ Postal Code

EMPLOYEE I.D. NO. FROM YOUR ASSURE CARD | 1 | 1 | | 0 | 5 | 1 | 9 | 9 | 1 | | | | | | | | | | | | | | |

(Please DO NOT submit until all numbers can be reported)

Mail completed form to:

Great-West Life Health & Dental Benefits
P.O. Box 3050
Winnipeg MB R3C 4E5

Is this claim an adjustment to a previously paid claim? ❑ Yes ❑ No

Part 2 – CLAIMANT INFORMATION – THIS SECTION MUST LIST **ALL** CLAIMANT INFORMATION.
IMPORTANT – Original pharmacy receipts **MUST** be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee = 01; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

Part 3 – OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of School: _____

Address of School: _____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 – CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' Compensation Board or Government Plan? ❑ Yes ❑ No

If yes, please advise us of the name of the other insuring agency or plan: _____

Group Policy/Plan No.: _____ Cert./I.D. No.: _____

Spouse's day and month of birth: Day _____ Month _____

If this claim has been submitted under another plan, you **MUST** attach the original Explanation of Benefits statement from that plan and the **COPIES** of the receipts.

Part 5 – OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made? _____ Currency used _____

Nature of Illness _____ Purpose of Travelling _____

Date of Departure _____ Actual Return Date _____

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU.
PLEASE KEEP A COPY FOR YOUR RECORDS.