THE Great-West Life ASSURANCE COMPANY

UNIVERSITY OF MANITOBA SUPPLEMENTARY HEALTH PLAN AND HEALTHCARE SPENDING ACCOUNT (HCSA) CLAIM FORM

UNIVERSITY OF MANITOBA

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

Instructions: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.

Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

Important: If you are covered under more than one plan you should submit your claims to both plans before using your HCSA. If, in the above selection box, you choose **Supp Health Plan Only** this claim will not be processed under the HCSA. If you choose **HCSA Only** this claim will not be processed under the Supp Health Plan. If you choose **Both**, this claim will be processed under both the Supp Health Plan and the HCSA. This claim form is intended for use only by employees who are members of both the University of Manitoba's Supplementary Health Plan and the Healthcare Spending Account (HCSA). Please answer all questions and complete both sides of this form. 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.

You can download this customized claim form by visiting the U of M website at: www.umanitoba.ca (go to "Human Resources").

EMPLOYEE INFORMATION

PLAN NUMBER	DIVISION NUMBER		PLAN NAME	Language Preference
20778	**001**	☐ FULL TIME ☐ PART TIME	**University of Manitoba (Regular Staff)**	☐ English ☐ French

EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE NAME	DATE OF BIRTH (Year / Month / Day)

ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE	PHONE #
				HOME: WORK:

COORDINATION OF BENEFITS

1. Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy Number _____
2. Is any member of your family (other than yourself) insured as an employee under the University of Manitoba plan 20778 or as a retiree under the University of Manitoba plan 44870? ☐ Yes ☐ No
3. If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth _____ / _____ Month / Day
4. Is treatment required as the result of an accident? ☐ Yes ☐ No
   If "Yes", provide date, location and explain how accident happened _____
   Is a claim being made for Workers Compensation benefits? ☐ Yes ☐ No

DEPENDENT INFORMATION

(to be completed if claim includes any expenses for a dependent.)

Patient Name	Relationship to Employee	Date of Birth Year	Month	Day	Does patient reside with you? YES NO	Students: Full-Time Student? YES NO	Students: If student, how many hours per week?	Employment: Employed? YES NO	Employment: How many hours worked per week?
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	
					☐ ☐	☐ ☐		☐ ☐	

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CLAIM DETAILS	DRUG EXPENSES		OTHER EXPENSES	
Patient Name	Number of Receipts	Total Charge	Type of Expense	Total Charge
	Total Charges		Total Charges	

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

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 to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents. I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada). I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

Claims Submission Instructions	
Coordinating Your Health and Dental Claims (coverage provided by the U of M plans and your spousal coverage)	**Claims for you:** • For Health claims submit to U of M Health Plan (GWL) first. Then submit any remaining unpaid expenses to your spouse's plan (along with GWL Explanation of Benefits). • For Dental claims submit to U of M Dental Plan (Blue Cross) first. Then submit to your spouse's plan (along with Blue Cross Explanation of Benefits). • Last, submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents). **Claims for your spouse:** • For Health and Dental claims submit to your spouse's plan first. • For Health claims, submit to U of M Health Plan (GWL) next, for reimbursement from the Health Plan and your HCSA (along with Explanation of Benefits from first insurer). • For Dental claims submit to U of M Dental Plan (Blue Cross) next (along with Explanation of Benefits from first insurer). • For Dental claims, last submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents). **Claims for your dependent children:** • For Health and Dental claims submit first to the plan of the parent whose birthday is first in the calendar year. • Next, submit any remaining unpaid expenses to the plan of the other parent (along with Explanation of Benefits from first insurer). • Last, submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents).
Dental Claims (if you have no spousal dental coverage)	• Submit Dental claims to U of M Dental Plan (Blue Cross) first. • Submit to U of M HCSA (GWL) for any unpaid portion (along with Blue Cross Explanation of Benefits).
Health Claims (if you have no spousal health coverage)	• Submit Health claims to U of M Health Plan (GWL) for reimbursement from both the Health Plan and your HCSA.
Visioncare Claims	• For a Visioncare claim, if you have Visioncare coverage through your spouse's plan, the claim must be submitted to your spouse's plan first. You can then submit any unpaid portion to the U of M HCSA (along with all Explanation of Benefits documents).

Send your completed Claim Form to:

Great-West Life
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg, MB R3C 0E6

When submitting your claim form to GWL, be sure to attach copies of all applicable bills and receipts as well as copies of all applicable Explanation of Benefits documents from other insurers.

If you have questions about your claims, contact Great-West Life at:

• Local: (204) 942-3589 • Toll Free: 1-800-957-9777

For the deaf or hearing impaired:

• Local: (204) 946-7281 • Toll Free: 1-800-990-6654

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