Manulife Financial

Group Benefits
e-Extended Health Care Claim

To be completed and printed by the plan member unless otherwise indicated. You must attach original receipts to this form for all expenses. Please retain copies of the receipts for your files as originals will not be returned.

If claiming for drug expenses: Is this claim for drug expenses **only**? ◯ Yes ◯ No
Do you have a Manulife Financial pay-direct drug card? ◯ Yes ◯ No

1 Plan member information

Your I.D card outlines your:
- plan no.
- account/division no.
- certificate no.

Plan no.	**Acct./Div. no.**	**Certificate no.**	Plan sponsor name

Plan member name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

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

Are these expenses eligible for coverage under workers' compensation? ◯ Yes ◯ No

Are you, your spouse or dependents covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If "Yes," please keep photocopies of all receipts you submit with this claim. You will need to submit them to your secondary carrier.

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan no.	Spouse's certificate no.

2 Patient information

You will need to complete this section for all expenses that you are claiming.

List each patient on a separate line.

Patient's name	**Date of birth** (dd/mmm/yyyy)	**Relationship to plan member**	**If the patient is a student 18 or older, please provide**	
			School and city	**If employed, hrs worked per week**

3 Drug expenses

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (D.I.N.) and the name of the drug.
- You are not required to list this information on the form.

4 Practitioner's/ Paramedical expenses

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses you will need to attach an **itemized statement** and/or receipt from the practitioner stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

If your claim is for psychotherapy, please indicate type (individual, family, group, marriage) on your itemized statement or receipt.

Was the patient referred by a physician? ◯ Yes ◯ No

5 Equipment and appliance expenses

For equipment and appliance expenses Manulife requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Briefly describe the activities requiring the use of this item.

How long is the equipment required? **From** Date (dd/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has the rental equipment been returned? ◯ Yes ◯ No

6 Vision Care expenses

Your supplier must complete this section after you have printed the form.

Please enclose an itemized receipt indicating:

- patient's name,
- cost of contact lenses,
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- treatment and
- date dispensed.

For eye glasses and elective contact lenses:

Is this the first pair of glasses or contact lenses for the patient? ◯ Yes ◯ No

Has the patient's prescription changed? ◯ Yes ◯ No

For medically necessary contact lenses:

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ◯ Yes ◯ No

Can visual acuity be improved with contact lenses by at least 2 lines on the Snellen chart over the best possible vision with glasses? ◯ Yes ◯ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯ Yes ◯ No

Signature of supplier | Date signed (dd/mmm/yyyy)

7 Claims confirmation

NOTE - You must attach ORIGINAL RECEIPTS for all expenses.

Total amount of ALL receipts submitted **$**

I certify that all goods or services being claimed have been received by me/my dependents.

I certify that the information in this form is true and complete, to the best of my knowledge.
I authorize any health care provider, other insurance company, workers' compensation board, my employer, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process this claim.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.
I agree that a photocopy of this authorization shall be as valid as the original.

Please sign here

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

Print

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At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

8 Mailing instructions

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

If you live outside Quebec:
Manulife Financial Group Benefits
Health Claims
P.O. Box 1653
Waterloo, ON N2J 4W1

If you live in Quebec:
Manulife Financial Group Benefits
Health Claims
P.O. Box 2580, Station B
Montreal, QC H3B 5C6

Ce document est aussi disponible en français à l'adresse www.manuvie.com/assurancecollective