Manulife Financial

Extended Health Care Claim

To be completed by the plan member unless otherwise indicated.
Original receipts must be attached for all expenses. ***(Please attach to the back of this form.)***
Please retain copies for your files as original receipts 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/ Employee information

You can obtain your plan/group no., account/division no. and your certificate no. from your I.D. card.

Plan/Group no.	**Acct./Div. no.**	**Certificate no.**	Plan sponsor/Employer

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

Plan member/Employee 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 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 (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan/group no.	Spouse's certificate no.

2 Patient information

Complete for all expenses. Use one line per patient.

	Patient's name	**Date of birth** (dd/mmm/yyyy) (1st Claim only)	**Relationship to plan member** (1st Claim only)	**Complete if patient is a student 18 or older *** **School and city**	**If employed, hrs worked per week**
1					
2					
3					
4					
5					
6					
7					

***** Please provide the graduation date of student

Patient # (from above chart) _____ Graduation date (dd/mmm/yyyy) _____

Please complete reverse

Manulife Financial

MANULIFE FINANCIAL
GROUP HEALTH CLAIMS
PO BOX 1653
WATERLOO ON N2J 4W1

Please place your completed claim form in an envelope and mail it to this address.

3 Drug expenses

- Attach your prescription drug receipts to the back of 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 please attach an **itemized statement** and/or receipt 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 for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

Was 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).

Indicate the activities requiring the use of this item.

Duration equipment is required. **From** Date (dd/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has rental equipment been returned? ◯ Yes ◯ No

6 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached 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/employee

Date signed (dd/mmm/yyyy)

Copies of receipts must be attached for all expenses.

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.