ASSURE CARD CLAIM FORM

(For Drug Card Claims Only)

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.

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

Employer Name: _____

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

THE Great-West Life ASSURANCE COMPANY

Mail completed form to:
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 4E5

Do you want any unpaid portion of your claim processed through your HealthCare Spending account? (if applicable) ☐ Yes ☐ No

If patient is other than employee's spouse or child under 21, is employee entitled to claim a medical expense tax credit under the Income Tax Act (Canada) in respect of the patient? ☐ Yes ☐ No

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 _____

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 authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the 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.

CLEAR

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