Completing the **Healthcare Expenses Statement**

You can use the Healthcare Expenses Statement form to submit claims for the following benefits:

- Healthcare
- Visioncare
- Prescription drugs

The form is divided into four sections:

Part 1: Employee Information

Information requested in this section identifies you and your group benefits plan.

When accessing this form on *GroupNet for Plan Members*, information will be pre-filled to the greatest extent possible. Review the information to ensure it is complete and correct.

If any information shown requires a change and/or correction, click on the blue text and edit as appropriate.

If you are completing this section, provide your Employee ID number, plan number, division number, and plan name. Depending on where you look up the information, the plan number and plan name may be referred to as policy number and name. You can find the information you need on your plan ID card, on the Explanation of Benefits statement, or from your plan sponsor (i.e. employer). If you do not know your division number, leave it blank, as it is not pertinent to your claim submission.

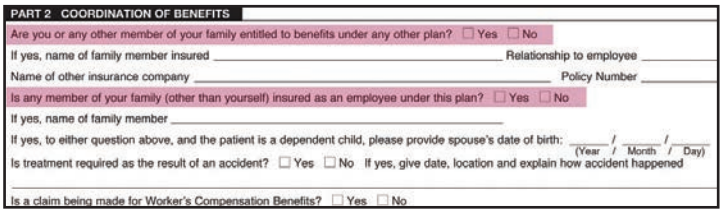
Part 2: Coordination of Benefits

The person you are submitting a claim for may be covered under government plans, or the benefits plan of a spouse. This section helps us determine how your claim should be processed depending on your age and circumstances.

Read this section to determine if any of the questions apply to you. If you are claiming for yourself or a family member, and are covered under the benefits plan of a spouse (common law or married), provide the name of your spouse's insurer, and the policy number.

If you or any other family member is covered under a benefits plan other than this Great-West plan, check "Yes" when asked, "Are you or any other member of your family entitled to benefits under any other plan?"

If any other family member is insured under this benefits plan with their own benefits (i.e. are employed by the same employer as yourself), check "Yes" when asked, "Is any member of your family (other than yourself) insured as an employee under this plan?" If you have answered "Yes" to this question, provide your spouse's date of birth.


PART 2 COORDINATION OF BENEFITS

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 _____

Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: ____ / ____ / ____ (Year / Month / Day)

Is treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location and explain how accident happened

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

Birthdate information is very important when submitting claims for a dependent child who has coverage under both you and your spouse, as the earliest birthdate (month/day, not year) is used to determine whose plan pays for the claim.

Part 3: Dependant Information

Information requested in this section identifies the dependants covered under your benefits plan. Complete this section if you are making a claim for one or more of your dependants.

Part 4: Claim Details

Information requested in this section provides details about the claim(s) you are making. All original receipts must be attached to each claim submission (receipts will not be returned).

THE Great-West Life ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1-844-393-2334

The Construction Industry's Benefit Plan
211-3823 Henning Drive
Burnaby, BC V5C 6P3

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

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: Please answer all questions. 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.

Please print

PART 1 EMPLOYEE INFORMATION

PLAN NUMBER	DIVISION NUMBER	PLAN NAME
		The Construction Industry's Benefit Plan

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

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

PART 2 COORDINATION OF BENEFITS

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 _____

Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Year / Month / Day)

Is treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location and explain how accident happened

_____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

PART 3 DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth Year	Month	Day	Does patient reside with you? YES	NO	Full-Time Student? YES	NO	If child over 18 years: If student, how many hours per week?	Employed? YES	NO	How many hours worked per week?
					☐	☐	☐	☐		☐	☐	
					☐	☐	☐	☐		☐	☐	
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PART 4 CLAIM DETAILS *(If additional space is needed, attach a separate page)*

DRUG EXPENSES

Patient Name	Number of Receipts	Total Charge

OTHER EXPENSES

Type of Expense	Nature of Illness	Total Charge

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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

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, located within or outside Canada, 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 the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____