



**IMPORTANT:** Payment may be delayed if this form is not fully completed.  
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'S STATEMENT**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employee Home Mailing Address \_\_\_\_\_

Group or Plan Name HALIFAX PORT I.L.A. / H.E.A. WELFARE TRUST FUND Plan Number 56072 Work Card Number \_\_\_\_\_ DIV # \_\_\_\_\_

- Are any of your eligible dependents insured as an employee under this plan?  Yes  No  
If yes, name of eligible dependent \_\_\_\_\_ I.D. Number \_\_\_\_\_
- Are you or any of your eligible dependents entitled to medical benefits under any other plan?  Yes  No  
If yes, name of eligible dependent insured \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Name of other insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_
- If yes to question 1 or 2 above, and the patient is a dependent child, give: Employee's birthdate (Day/Mo.) \_\_\_\_\_  
Spouse's birthdate (Day/Mo.) \_\_\_\_\_
- 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

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's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART 2: DEPENDENT INFORMATION**

(To be completed if claim includes any expense for a dependent.)

| Patient Name | Relationship to Employee | Date of Birth<br>Year Month Day | Does patient reside with you?                            | If child over 18 years                                   |  |  |   |
|--------------|--------------------------|---------------------------------|--|--|--|--|---|
|              |                          |                                 |  | Full-Time Student?                                       | If student, how many hours per week at school? | Employed?  | If yes, how many hours worked per week? |
| _____        | _____                    | _____                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                   |
| _____        | _____                    | _____                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                   |
| _____        | _____                    | _____                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                   |
| _____        | _____                    | _____                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                   |
| _____        | _____                    | _____                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                   |

**PART 3: CLAIM INFORMATION**

**NOTE:** Please attach a receipt or bill for each item claimed. Receipts and bills, other than those required for government drug plans, are part of our records and will not be returned. The Explanation of Benefits that will accompany our cheque should be kept for your records and for Income Tax purposes.

**A. DRUG CHARGES**

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE.

| Name of Patient | For each Patient Show Only<br>Date of First and Last Receipt | No. of Receipts | Total Charge |
|-----------------|--|-----------------|--------------|
| _____           | From _____ To _____  | _____           | \$ _____     |
| _____           | From _____ To _____  | _____           | \$ _____     |
| _____           | From _____ To _____  | _____           | \$ _____     |
| _____           | From _____ To _____  | _____           | \$ _____     |
| _____           | From _____ To _____  | _____           | \$ _____     |

Please ask your pharmacist to indicate Prescription Number, Drug Identification Number (DIN) and brand name on each drug receipt submitted.