Manulife Financial

Group Benefits Health Care Expense

SECTION 1 - TO BE COMPLETED BY PLAN MEMBER

McGill University — **85210**

Plan sponsor | Plan contract number | Plan member certificate number

Plan member – Last name | First name and initial | Date of birth (dd/mmm/yyyy)

Plan member – Address | Number | Street | City | Province | Postal code

1. Do you have a Manulife drug card? ☐ No ☐ Yes
2. Is this claim a result of traveling outside the country? ☐ No ☐ Yes If yes, from _____ (dd/mmm/yyyy) to _____ (dd/mmm/yyyy)
3. Are any of these expenses related to any type of workers' compensation claim? ☐ No ☐ Yes

Coordination of Benefits

4. Are benefits available from another group plan? ☐ No ☐ Yes
   If yes, please provide the following information _____ Insurance carrier name | Plan contract number
5. If other coverage was available and has recently terminated, please provide termination date _____ (dd/mmm/yyyy)

The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Manulife Financial with a completed claim form and a copy of the settlement provided by the other carrier. Claims for dependant(s) must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.

Claim Information

Please complete all requested information and list expenses in date order. Use a separate line for each person and attach original receipts. Incomplete forms or photocopied receipts cannot be processed for payment.

Patient name	Relationship to plan member	Date of birth (dd/mmm/yyyy)	If dependant: Full-time student?	If dependant: Full-time work?	Receipt date (dd/mmm/yyyy)	Description of expense*	Total charge

* Please identify the type of health expense (eg.drugs, physiotherapy, etc.)

SECTION 2 - DECLARATION & AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Any information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers 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, where appropriate, to have any inaccurate information corrected.

Plan Member's Signature | **Date** (dd/mmm/yyyy)

Group Claims Department
PO BOX 2580 STN B
MONTREAL QC H3B 5C6

Telephone: 1-800-268-6195
Visit our website: www.manulife.ca/groupbenefits