Manulife Financial

For your future™

Group Benefits
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.

All inquiries can be directed to the Group Benefits Customer Service Centre at 1-800-815-8333.

If claiming for prescription drug expenses: Is this claim for prescription drug expenses **only**? ◯ Yes ◯ No

Do you have a Manulife Financial pay-direct prescription drug card? ◯ Yes ◯ No

1 Plan member information

You can obtain your plan no. and your payroll no. from your I.D. card.

Plan no.	**Payroll no.**	Plan sponsor **City of Toronto**

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Are these expenses eligible for coverage under any type of workers' compensation board? ◯ 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 no.	Spouse's certificate no.

HCSA
Applicable to Non-Union/ Accountability Officers/ Elected Officials only.

◯ Check here to use your Health Care Spending Account (HCSA) to reimburse any unpaid portion of this claim.
(If the patient has health coverage under another plan, you **must** submit any unpaid amount from this claim to that plan **before** using your HCSA.)

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**

3 Prescription 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 prescription drug.
- You are not required to list this information on the form.

4 Practitioner's/ Paramedical expenses

For the following practitioners (e.g. Chiropractor, Podiatrist, Masseur), choose one of the following coverage options:

NOT APPLICABLE TO NON-UNION/ACCOUNTABILITY OFFICERS/ELECTED OFFICIALS, FIREFIGHTERS AND CUPE LOCAL 79 RECREATION WORKERS

◯ Option 1: the current maximum per practitioner per person, per benefit year

OR, alternatively

◯ Option 2: a maximum of $800 for one (1) practitioner per person, per benefit year

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.

Please complete next page.

5 Equipment and appliance expenses

For equipment and appliance expenses Manulife Financial 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 Vision Care expenses

Please enclose an itemized receipt indicating:

- patient's name,
- cost of contact lenses,
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- treatment and
- date dispensed.

7 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, any type of workers' compensation board, my plan sponsor, 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 | Date signed (dd/mmm/yyyy)

Print

Reset

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 service 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.

8 Mailing instructions

Please mail your completed claim form and receipts to the address below.

Manulife Financial
Group Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1