

**In-Canada Expenses Claim Form** 

PROTECTED "B" WHEN COMPLETED

canada

**THIS IS A:** □ Claim for benefits □ Pretreatment/estimate

# PART 1 - Instructions

Please use this form to submit claims incurred in-Canada to Canada Life for reimbursement.

- 1. Complete page 1 and 2 of this form in full.
- 2. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
- 3. Send to the appropriate Canada Life address. See PART 10.

All claims under the Public Service Health Care Plan (PSHCP) must be submitted through the plan member. We may disclose personal information about

| claims with your employer, your service provider and /or a person acting on your behalf when necessary to confirm eligibility and to mutually manage the claim.  |
|--|
| PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your Public Service Health Care Plan (PSHCP) benefit card, the Canada Life PSHCP Member Services website or Part 10 for our contact information. |
| Plan name Public Service Health Care Plan  Plan number  Plan number  Plan number   |
| Plan member name   |
| First name Last name   |
| Plan member address  |
| Number and street  City or town  Province/Territory/State  Postal/Zip Code   |
| Country Date of birth Day Month Year   |
| PART 3 – Coordination of benefits - Complete this section to indicate whether you or any member of your family have benefit coverage under any other plan.   |
| 1. Are you or any member of your family entitled to any other health insurance plan for the expenses being claimed? $\square$ Yes $\square$ No If yes, please answer the questions below.  |
| 2. Who does the other insurance belong to? Self Spouse or common-law partner Dependant child  First name  Last name  |
| 3. If the other insurance plan belongs to your spouse or common-law partner and the claimant is a dependant child, please provide your spouse or common-law partner's date of birth. Day Month   |
| 4. Is the other insurance also with Canada Life?  \( \subseteq \text{Yes} \subseteq \text{No} \)   |
| If yes, please provide: Canada Life plan number Certificate number   |
| Other insurance plan member's signature of authorization: X  |
| * If other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach to this claim the Explanation of Benefits (EOB) provided by the other insurer. An EOB is required even if no benefits were paid by other insurance.                |
| ** We assess claims using the information you provided during Positive Enrolment, any discrepancies may delay our assessment of your claim.  |
| PART 4 – Information about your claim - Complete this section to provide us additional information about your claim.   |
| 1. Is treatment required as a result of an accident?   |
| 2. Are any of the expenses incurred outside your province/territory of residence?  Yes No If yes, please provide the date of departure from your home province/territory.  Month  Were you on official travel status for government business?  Yes No                                      |
| DADT 5. Claimant information. Complete few all expenses and line per claimant.   |

| Claiman    | t name    | Claimant's relationship to p |                              | ip to plan         | Claimant's date of birth |       | If dependant child is between<br>21 and 25 years old, are they a<br>full-time student? |     |    |
|------------|-----------|------------------------------|------------------------------|--------------------|--------------------------|-------|--|-----|----|
| First name | Last name | Self                         | Spouse or common-law partner | Dependant<br>child | Day                      | Month | Year   | Yes | No |
|            |           |                              |                              |                    |                          |       |  |     |    |
|            |           |                              |                              |                    |                          |       |  |     |    |
|            |           |                              |                              |                    |                          |       |  |     |    |
|            |           |                              |                              |                    |                          |       |  |     |    |



# Public Service Health Care Plan In-Canada Expenses Claim Form

PROTECTED "B" WHEN COMPLETED

| Claimant name - First and last name  | Type of expense  | Amount claimed   |
|--|--|--|
|  | туро от охранов  | 7 0  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| PART 7 - Vision care expenses - Complete thi   | s section only if glasses/lenses were required due to accide   | ent or surgery.  |
| Claimant's name:   |  | • •  |
| Date of accident/surgery: Day Month Year   | <u> </u>   |  |
| Details of accident/surgery:   | J  |  |
| Details of accident/surgery.   |  |  |
| PART 8 – Privacy   |  |  |
| •  |  |  |
| t Canada Life, we recognize and respect the importance o   | of privacy. Personal information that we collect will be used for<br>er to the PSHCP Privacy Statement (canada ca/en/treasury-b  |  |
| aim and administering the group benefits plan. Please refe   |  |  |
|  |  | n how your privacy is protected.   |
| lans/health-care-plan/public-service-health-care-plan-priva  | acy-statement-september-2009.html) for further information on significant constraints and the PSHCP Privacy St.  |  |
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Please send your claim to Canada Life:

## **ONLINE**

canadalife.com/pshcp Sign into your Member Services account to submit claims or estimates.

## Questions? Call Canada Life:

Call toll free 1-855-415-4414

### MAIL

Winnipeg Benefit Payments PO Box 99451 Stn Main Winnipeg MB R3C 1E6

#### ....

Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us:

TTY to Voice: 711 • Voice to TTY: 1-800-855-0511