Public Service Health Care Plan
In-Canada Expenses Claim Form

PROTECTED "B" WHEN COMPLETED

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 member certificate 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
   Date of accident: Day | Month | Year
   Accident type: ☐ Motor vehicle ☐ Workplace ☐ If other, please explain. _____
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. Day | Month | Year
   Were you on official travel status for government business? ☐ Yes ☐ No

PART 5 – Claimant information - Complete for all expenses; one line per claimant.

Claimant name		Claimant's relationship to plan member			Claimant's date of birth			If dependant child is between 21 and 25 years old, are they a full-time student?	
First name	Last name	Self	Spouse or common-law partner	Dependant child	Day	Month	Year	Yes	No
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐

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PART 6 – Claim details - If additional space is needed, attach a separate page.

Claimant name - First and last name	Type of expense	Amount claimed

PART 7 – Vision care expenses - Complete this section only if glasses/lenses were required due to accident or surgery.

Claimant's name: _____

Date of accident/surgery: Day | Month | Year

Details of accident/surgery: _____

PART 8 – Privacy

At Canada 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. Please refer to the PSHCP Privacy Statement *(canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html) for further information on how your privacy is protected.*

Where there is a difference between the Privacy Act *(//laws-lois.justice.gc.ca/eng/acts/P-21/) and the PSHCP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements. 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 Canada Life's Chief Compliance Officer or refer to* canadalife.com.

PART 9 – Confirmation, Authorization and Signature

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pshcp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP Privacy Statement. For the purposes of appeals, audits, or in the case of overpayments and/or erroneous payments which I have not reimbursed to Canada Life, I agree that Canada Life may disclose personal information related to such payment to the Plan Sponsor, the Treasury Board of Canada Secretariat, and the Federal PSHCP Administration Authority. The Plan Sponsor/Treasury Board of Canada Secretariat may disclose this personal information to government institutions so that the overpayments and/or erroneous payments and associated interest (if applicable) can be deducted or set-off from any money due or payable to me by His Majesty.

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

Plan member signature X _____ **Date** Day | Month | Year

PART 10 – Submitting your claim

Please send your claim to Canada Life:

ONLINE

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

MAIL

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

Questions? Call Canada Life:
Call toll free 1-855-415-4414

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

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