canada life™

Public Service Health Care Plan
Gender-Affirming Care Application Form

PROTECTED "B" WHEN COMPLETED

THIS IS A: ☐ Claim for benefits ☐ Pretreatment/estimate

PART 1 – Instructions

Please use this form to submit your application for gender affirmation care to Canada Life. This form must be submitted prior to incurring any expenses for gender-affirming care.

1. Complete parts 2 to 6 in full and have your attending physician or nurse practitioner complete parts 7 to 8.
2. Attach receipts/estimates for all services and retain copies for your files as originals will not be returned.
3. Send to Canada Life. See part 9.
4. Please apply for coverage through the appropriate provincial/territorial health program before submitting this application to Canada Life (if applicable).

Please note that physician's fees for providing medical information are not covered under the Public Service Health Care Plan (PSHCP).

All forms under the 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 your assessment.

PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your PSHCP benefit card, the Canada Life PSHCP Member Services website or Part 9 for our contact information.

Plan name	Plan number	Plan member certificate number
Public Service Health Care Plan		

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 – Patient information

Patient name		Patient's relationship to plan member			Patient's date of birth		
First name	Last name	Self	Spouse or common-law partner	Dependant child	Day	Month	Year
		☐	☐	☐			

PART 4 – Coordination of benefits - Complete this section if you or the patient have benefit coverage under any other benefit plan.

1. Is this patient entitled to any other health insurance plan benefits? ☐ 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.

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PART 5 – 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 application 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 6 – 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.

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

Plan member signature X ______________________ **Date** Day ____ Month ____ Year ____

PART 7 – Confirmation of eligibility for gender-affirming care

Confirm the patient is under your care for gender affirmation and attest to the medical necessity. Any additional information you can provide, such as details of an existing diagnosis, may assist in determining eligible coverage.

1. List all physician and/or laboratory services being requested.
2. Confirm where the care will be rendered (e.g., hospital, clinic, etc.) ______
3. Has the patient applied to their provincial/territorial health care plan or program for coverage of gender-affirming care? ☐ Yes ☐ No

   If no, please indicate why patient has not applied to their provincial/territorial health care plan or program:
4. Will the services be performed in the patient's home province/territory? ☐ Yes ☐ No

   a. If “Yes”, confirm which of the services listed above are eligible for coverage under the patient's provincial/territorial health plan.

   Note: The patient must apply for provincial/territorial coverage and provide confirmation of approval or denial from the provincial/territorial plan or program.

   b. If “No”, proceed to Question 5.
5. Complete only if the patient will be travelling to a different province/territory to obtain the health care.

   a. Confirm the province/territory where the services are to be performed. ______

   b. Are the services being obtained out-of-province available in the patient's home province/territory? ☐ Yes ☐ No

   If yes, please indicate why patient is seeking care outside of home province/territory.

   c. The patient must provide written confirmation from their provincial/territorial plan if any portion of the services will be funded, including amounts.
6. Provide other comments or additional information that may assist with reviewing the application.

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PART 8 – Attending physician's or nurse practitioner's confirmation and signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

Physician or nurse practitioner's name

Name	Phone number

Physician or nurse practitioner's address

Number and street	City or town	Province/Territory/State	Postal/Zip Code

Signature X ______________________ **Date** Day ____ Month ____ Year ____

PART 9 – Submitting your application

Please send the completed form to:

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
Monday to Friday from 8 am to 5 pm, your local time.

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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