

# Group Benefits Extended Health Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be provided for all expenses.  
Please retain copies for your files as original receipts will not be returned.

**1 Plan member information**

Plan contract number \_\_\_\_\_ Plan member certificate number \_\_\_\_\_

Plan sponsor \_\_\_\_\_

Plan member name (first, middle initial, last) \_\_\_\_\_

Date of birth (dd/mmm/yyyy) \_\_\_\_\_ Daytime phone number \_\_\_\_\_

Plan member address (number, street and apt.) \_\_\_\_\_

City/Town \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

**2 Workers' compensation board**

Are any of the expenses associated with a work related incident AND eligible for workers' compensation benefits?  Yes  No

If yes, submit these expenses to your provincial workers' compensation board.

**3 Coordination of benefits**

Are you, your spouse or dependants 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 contract number \_\_\_\_\_ Spouse's plan member certificate number \_\_\_\_\_

If Manulife is your secondary carrier, include copies of the receipts and the explanation of benefits from your primary carrier.

4 Patient information	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
Complete for all expenses. Use one line per patient.	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

**5 Prescription drug expenses**

- Include your prescription drug receipts with this form.
- All receipts must contain the drug identification number (DIN) and the name of the prescription drug.
- You are not required to list this information on the form.

**6 Practitioner/Paramedical expenses**

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please include 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.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

**7 Equipment and appliance expenses**

For equipment and appliance expenses Manulife 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

**Please complete next page.**

