

ASSURE CARD CLAIM FORM
(For Drug Card Claims Only)

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Part 1 – EMPLOYEE INFORMATION – This section **MUST** be completed in full by the employee.

Employer Name: _____

Employee Name: _____

Employee Address: _____

Box No./Apt. No., Number and Street

City or Town

Province

Postal Code

**EMPLOYEE I.D. NO.
FROM YOUR ASSURE
CARD**

1 1

(Please DO NOT submit until all numbers can be reported)

Mail completed form to:
Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

Is this claim an adjustment to a previously paid claim? Yes No

Part 2 – CLAIMANT INFORMATION – THIS SECTION MUST LIST **ALL** CLAIMANT INFORMATION.

IMPORTANT – Original pharmacy receipts **MUST** be attached for drugs being claimed.

Patient Name	Patient Code*	Patient Date of Birth (DD/MM/YY)	Number of Receipts	Amount Charged

*PATIENT CODE: Employee = 01; Spouse = 02; Dependent Child = 03; Overage Student = 04; Disabled Dependent = 05

Part 3 – OVERAGE STUDENT INFORMATION (Patient Code 04)

If your policy provides coverage for overage students, please complete the following:

Name of School: _____

Address of School: _____

Please contact your Employee Benefit Office for further information on this coverage.

Part 4 – CO-ORDINATION OF BENEFITS

Is your spouse covered for these expenses by any other Health Plan, Group Insurance Plan, Workers' Compensation Board or Government Plan? Yes No

If yes, please advise us of the name of the other insuring agency or plan: _____

Group Policy/Plan No.: _____ Cert./I.D. No.: _____

Spouse's day and month of birth: Day _____ Month _____

If this claim has been submitted under another plan, you **MUST** attach the original Explanation of Benefits statement from that plan and the **COPIES** of the receipts.

Part 5 – OUT OF COUNTRY CLAIM

If this claim is for medication purchased outside of Canada please indicate the following:

In what country was the purchase made? _____ Currency used _____

Nature of Illness _____ Purpose of Travelling _____

Date of Departure _____ Actual Return Date _____

At Great-West 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. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West 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 certify that the information given is true, correct, and complete to the best of my knowledge.

EMPLOYEE SIGNATURE: _____ DATE: _____

FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE CLAIM BEING RETURNED TO YOU. PLEASE KEEP A COPY FOR YOUR RECORDS.