

UNIVERSITY OF MANITOBA SUPPLEMENTARY HEALTH PLAN AND HEALTHCARE SPENDING ACCOUNT (HCSA) CLAIM FORM



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nstructions:	Attach the bills and	d receipts for all expe	nses and	d it	emi	ze tl	hem	by pro	ovidin	g all th	ne info	ormation i	equested.			
Note:		eipts, other than those retain the itemization														
mportant:	If you are covered under more than one plan you should submit your claims to both plans before using your HCSA. If, in the above selection box, you choose Supp Health Plan Only this claim will not be processed under the HCSA. If you choose HCSA Only this claim will not be processed under the Supp Health Plan. If you choose Both , this claim will be processed under both the Supp Health Plan and the HCSA. This claim form is intended for use only by employees who are members of both the University of Manitoba's Supplementary Health Plan and the Healthcare Spending Account (HCSA). Please answer all questions and complete both sides of this form. This claim will be returned to you if it is incomplete or contains errors. 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.															
		d claim form by visiting	ig the U	OT	IVI V	vebs	site a	II WW	w.um	anitob	a.ca (go to Hu	man Resol	irces).		
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20778			☐ FULL TIME ☐ PART TIME							of Maı	nitoba			anguage] Englis	guage Preference English	
20778 001 EMPLOYEE IDENTIFICATION NUMBER			MPLOYEE NAME				<u> </u>	2 St. Wallion				(1.094.01		D/	ATE OF	BIRTH oth / Day)
ADDRESS: N	NUMBER AND STREE	T TOWN		Р	PRO\	/INC	E	PC	STAL	CODE		HONE #	I	WOR	K:	
COORDINAT	TION OF BENEFITS															
		of your family entitled to	o benefit	S I	ınde	r an	v oth	er plai	 1?	Yes	□N	0				
•	•	insured					•	•					nplovee			
-	-	any														
2. Is any mer	mber of your family (other than yourself) ins														nder the
3. If "Yes" to	either question abov	e, and the patient is a	depende	ent	chile	d, pl	ease	provid	de spo	use's	date	of birth	Month	_ /	у	
4. Is treatmen	nt required as the res	sult of an accident?			Υe	es	☐ No)								
If "Yes", pr	rovide date, location	and explain how accid	ent happ	en	ed .											
		kers Compensation bei				es	□ No)								
	T INFORMATION ted if claim includes an	v expenses for a depende	ent.)									St	udents		Emp	oloyment
	atient Name	Relationship to Employee			Da Year	ate c	of Birth	_	resi	es pat de with ES N	you?	Full-Time Student? YES NO	If student, h many hou per week	rs	ployed?	How many hours worked per week?
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CLAIM DETAILS	DRUG EXP	ENSES	OTHER EXPENSES				
Patient Name Number of Receipts		Total Charge	Type of Expense	Total Charge			
	Total Charges		Total Charges				

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

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 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 all goods and services being claimed have been received by me, my spouse and/or my dependents. I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada). I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature	Date	

	Claims Submission Instructions
Coordinating Your Health and Dental Claims (coverage provided by the U of M plans and your spousal coverage)	Claims for you: For Health claims submit to U of M Health Plan (GWL) first. Then submit any remaining unpaid expenses to your spouse's plan (along with GWL Explanation of Benefits). For Dental claims submit to U of M Dental Plan (Blue Cross) first. Then submit to your spouse's plan (along with Blue Cross Explanation of Benefits). Last, submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents). Claims for your spouse: For Health and Dental claims submit to your spouse's plan first. For Health claims, submit to U of M Health Plan (GWL) next, for reimbursement from the Health Plan and your HCSA (along with Explanation of Benefits from first insurer). For Dental claims submit to U of M Dental Plan (Blue Cross) next (along with Explanation of Benefits from first insurer). For Dental claims, last submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents). Claims for your dependent children: For Health and Dental claims submit first to the plan of the parent whose birthday is first in the calendar year. Next, submit any remaining unpaid expenses to the plan of the other parent (along with Explanation
Dental Claims	of Benefits from first insurer). Last, submit to U of M HCSA (GWL) for any unpaid portion (along with all Explanation of Benefits documents). Submit Dental claims to U of M Dental Plan (Blue Cross) first.
(if you have no spousal dental coverage)	Submit to U of M HCSA (GWL) for any unpaid portion (along with Blue Cross Explanation of Benefits). A statistical basis of the statistical basis of the statistical basis of the statistic basis of
Health Claims (if you have no spousal health coverage)	Submit Health claims to U of M Health Plan (GWL) for reimbursement from both the Health Plan and your HCSA.
Visioncare Claims	 For a Visioncare claim, if you have Visioncare coverage through your spouse's plan, the claim must be submitted to your spouse's plan first. You can then submit any unpaid portion to the U of M HCSA (along with all Explanation of Benefits documents).

Send your completed Claim Form to:

Great-West Life Winnipeg Benefit Payments P.O. Box 3050 Winnipeg, MB R3C 0E6

When submitting your claim form to GWL, be sure to attach copies of all applicable bills and receipts as well as copies of all applicable Explanation of Benefits documents from other insurers.

If you have questions about your claims, contact Great-West Life at:

Toll Free: 1.800.957.9777
For the deaf or hearing impaired:
Toll Free: 1.800.990.6654