KINECTRICS INC. PENSIONERS HEALTHCARE EXPENSES STATEMENT

SEND THIS CLAIM TO:

The Canada Life Assurance Company

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1

Toll Free Inquiries: 1.800.957.9777

www.canadalife.com

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

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. 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.

Please print

PART 1 EMPLOYEE INFORMATION

PLAN NUMBER	PLAN NAME
51597	**KINECTRICS INC.**
EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE NAME — DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET — TOWN — PROVINCE — POSTAL CODE	PHONE # — HOME: — WORK:

PART 2 COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If yes, name of family member insured _____ Relationship to employee _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Year / Month / Day)

Is treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location and explain how accident happened

_____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

PART 3 DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth (Year / Month / Day)	Does patient reside with you? YES NO	Full-Time Student? YES NO	If child over 18 years: If student, how many hours per week?	Employed? YES NO	How many hours worked per week?
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	
			☐ ☐	☐ ☐		☐ ☐	

PART 4 CLAIM DETAILS *(If additional space is needed, attach a separate page)*

DRUG EXPENSES

Patient Name	Number of Receipts	Total Charge

OTHER EXPENSES

Type of Expense	Nature of Illness	Total Charge

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 dependents; and that my spouse and/or dependents 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.

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. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, 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.

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 www.canadalife.com.

Employee's Signature _____ Date _____

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