THE Great-West Life ASSURANCE COMPANY

Kinectrics Inc. OTC-NHP Claim

Prescribed Natural Health Products

(For all eligible PWU represented employees and pensioners)

FOR ACTIVE EMPLOYEES, THIS FORM IS AVAILABLE ON THE KINECTRICS INTRANET SITE.
FOR PENSIONERS, THE FORM IS AVAILABLE ON THE KINECTRICS WEBSITE.

Upon completion, please mail to:
Great-West Life Assurance Company
London Benefits Payments
255 Dufferin Avenue
London, ON N6A 4K1
Long distance inquiries: 1.800.318.6098

Employer Information

Plan Number	Name of Employer
58172	KINECTRICS INC.

Employee Information

Name of Employee	Employee Number	
	000	☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Common-law ☐ Widowed

Apt. No.	Street Address	City	Province	Postal Code	Date Of Birth	Day	Month	Year

Patient Information

Other family member(s) included in this claim.

Name	Relationship	Date of Birth

If claim is for dependent child, is that child:

Married?	☐ Yes	☐ No	
Enrolled as a full time student?	☐ Yes	☐ No	If Yes, name of school:
Employed:	☐ Yes	☐ No	
Handicapped?	☐ Yes	☐ No	

Other Coverage

Are any health benefits or services provided under any other group or health plan?

☐ Yes ☐ No ***If "Yes" provide the following:***

Is your spouse employed? ☐ Yes ☐ No	Spouse's Employer's Complete Address
Spouse's Name	
Spouse's Date of Birth	Name of Insurer
Spouse's Employer's Name	Policy Number

Occupational Injury

Were any of the expenses for which claim is being made related to an occupational sickness or injury?	☐ Yes	☐ No
If "Yes" has claim been reported to the Workplace Safety and Insurance Board?	☐ Yes	☐ No

Provide Patient's Name and Details

This Claim

Attach the prescription plus the itemized bill or receipts for each item of expense being claimed. Bills and receipts must remain with your claim. If copies are needed for any purpose, they should be obtained before your claim is submitted.

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.

Total Amount of this claim
$

Certified

I certify that the above statement and attachments are completed and correct.

Employee's Signature

Date		
Day	Month	Year

M635D(58172)-7/11 OTC-968-C006:0 (front) rev.03-11

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