Manulife

Group Benefits
Out-of-province/Out-of-Canada Health Claim
(for physician's fees and hospital services only)

- *To be completed by the plan member unless otherwise indicated.*
- *One form must be completed for each patient.*
- *Manulife will co-ordinate claim assessments on your behalf when you have individual travel health insurance coverage.*
- *Please attach copies of itemized statements from the provider of services to the BACK of this form. These will not be returned.*
- *Eligible expenses submitted in a foreign currency will be paid in Canadian funds.*
- *ANY COSTS INCURRED AS A RESULT OF OBTAINING ANY ADDITIONAL INFORMATION THAT IS REQUIRED BY MANULIFE IS THE RESPONSIBILITY OF THE PLAN MEMBER.*

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 Patient information

Complete for all expenses.

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

IMPORTANT: Claims MUST be submitted to your provincial plan and THEN submitted to Manulife with a copy of the statement of payment (or decline).

Is the patient covered under any other travel or group insurance plan for the expenses being claimed? ◯ Yes ◯ No

If ***yes***, please provide the following information:

	Name and address of insurance company	Type of policy	Plan contract number	Plan member certificate number	Name of person(s) policy issued to
1		◯ Ind.* ◯ Group**			
2		◯ Ind.* ◯ Group**			
3		◯ Ind.* ◯ Group**			
4		◯ Ind.* ◯ Group**			

* **"Ind."** refers to travel insurance purchased by the individual/family. ** **"Group"** refers to benefits provided through plan sponsor.

4 Claim information

Date of departure (dd/mmm/yyyy) _____ Date of return (dd/mmm/yyyy) _____ Province/country where treatment was provided _____

1. Describe when, how and where the injury/illness occurred.

Please complete next page.

4 Claim information (continued)

EMERGENCY CARE Treatment for an injury which occurs or an illness which begins while temporarily outside of province/Canada.

2. Was the patient previously treated for this condition any time prior to leaving province/Canada?

◯ Yes ◯ No If *yes*, please attach a letter from the treating Canadian physician stating the previous treatment rendered.

3. Did you receive a discount from the provider of service for any of the bills/invoices submitted?

◯ Yes ◯ No If *yes*, please submit original discounted bills/invoices for processing.

Additional comments regarding the Emergency Care claim:

5 Banking information and email address

Visit **manulife.ca/planmember** to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile menu OR complete this section.

Complete **only** when providing new or updated information.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.

Transit number | Institution number | Account number

By providing your email address, you will receive an email notification once your claim has been processed, including a link to **manulife.ca**, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit **manulife.ca/planmember** to register for your Plan Member secure site.

Email address (Please print clearly)

6 Authorization and consent

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim submission. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers, for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). **I agree** that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

I agree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Manulife's Privacy Policy is available at manulife.ca/groupbenefits, or from my Plan Sponsor.

If applicable, **I authorize** Manulife to deposit all payments due to me from the above-referenced Group Benefits Plan ("Payments") into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or by my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s) requested herein and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account to which I am not entitled, either by contract or by law, shall not form part of my property and shall be immediately refunded to Manulife, either by me, by my duly authorized representatives or by representatives of my estate.

If applicable, **I authorize** Manulife to use the email address provided as a means of communication with me related to my group benefits. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** that should the email address identified on this form change, I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can unsubscribe, remove my email address online or contact the Customer Service Centre at 1-800-268-6195 to have my email address removed.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

PLEASE SIGN HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy) _____

7 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:

Manulife Group Benefits
Health and Dental Claims, 500 G-B
500 KING ST N
WATERLOO ON N2J 4C6

If you live in Quebec:

Manulife Group Benefits
Health Claims and Dental Claims
2000 MANSFIELD ST
MONTREAL QC H3A 2Y9

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