Financial Services SISIP RARM Services financiers

Manulife Financial

Major Medical Supplementary Health Expense Claim

Group Policy # **90133 / 90134 / 90135**

(please circle the correct policy number)

Reset Print

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

1. MEMBER INFORMATION

Service Number (SN) | LTD/SIB Claim Number | Surname | First Name | Initials

Mailing Address | Date of Birth

City | Prov. | Postal Code

Are these expenses eligible for coverage under any type of workers' compensation board? ☐ Yes ☐ No

Are you, your spouse or dependants covered under any other plan for the expenses being claimed? ☐ Yes ☐ No

(If you answered "yes" to the previous question, please provide the following):

Spouse's Date of Birth | Name of Spouse's Insurance Company | Spouse's Plan No. | Spouse's Certificate No.

2. DEPENDANT INFORMATION

Complete for all expenses.
Use one line per dependant.

Dependant's Name	Date of birth (dd/mm/yyyy) (1st Claim only)	Relationship to Plan member (1st Claim only)	Complete if dependant is a student 18 or older	
			School and city	If employed, hrs worked per week

3. PRESCRIPTION DRUG EXPENSES

- Attach your prescription drug receipts to the back of this form.
- All receipts must contain the drug identification number (D.I.N.) and the name of the prescription drug
- You are not required to list this information on the form.

4. PRACTITIONER'S/PARAMEDICAL EXPENSES

(e.g. chiropractor, massage therapist, physiotherapist, etc.)

For practitioner/paramedical expenses please attach an **itemized statement** and/or receipt stating:

- patient name,
- name of practitioner,
- type of practitioner,
- date of service,
- length of visit,
- charge for treatment,
- date last paid by provincial plan (if applicable) and
- licence and/or registration number.

If for psychotherapy, please indicate type (individual, family, group, marriage) on your receipt.

Service Number (SN):

5. EQUIPMENT AND APPLIANCE EXPENSES

For equipment and appliance expenses Manulife Financial requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Indicate the activities requiring the use of this item.

Duration equipment is required. From Date dd/mm/yyyy To Date dd/mm/yyyy

Has rental equipment been returned? ☐ Yes ☐ No

6. VISION CARE EXPENSES (if applicable to your plan)

To be completed by supplier.

Please enclose an itemized receipt indicating:

- Patient's name,
- Cost of contact lenses,
- Cost of glasses,
- Dispensing fee,
- Cost of eye exam,
- Date of eye exam,
- Cost of tinting,
- Treatment and
- Date dispensed.

Eye glasses and elective contact lenses:
If your Vision care benefit requires a change in prescription, please have the supplier complete and sign below.

Is this the first pair of glasses or contact lenses? ☐ Yes ☐ No

Has the prescription changed? ☐ Yes ☐ No

Medically necessary contact lenses:
Please have the supplier complete and sign below.

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ☐ Yes ☐ No

Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses? ☐ Yes ☐ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ☐ Yes ☐ No

Signature of supplier | Date signed (dd/mm/yyyy)

7. CLAIMS CONFIRMATION & SIGNATURE

NOTE—
ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted $

I certify that all goods or services being claimed have been received by me/my dependants.

Declaration and Authorization by Applicant

I certify that the information in this form is true and complete, to the best of my knowledge, and does not contain a claim for any expenses previously paid for by any plan.

I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, and type of workers' compensation board, investigative agencies and my plan sponsor, to release and exchange such information requested by SISIP Financial Services, Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.

I authorize SISIP Financial Services, Manulife Financial and/or its claims service providers to collect, to use and to exchange with the persons or organizations listed above, only the necessary information needed for the purpose of plan administration including processing and investigating this claim.

If this claim is made on behalf of my spouse and/or dependants, I am authorized to disclose information about them, for the purpose of plan administration including processing and investigating this claim.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Please Sign Here

Signature of plan member | Date signed (dd/mm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

> Manulife employees, representatives, reinsurers, service providers and SISIP Financial Services in the performance of their jobs;
> Persons to whom you have granted access; and
> Persons authorized by law.

The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act* . You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

Mailing Instructions

Please return completed form to: Manulife Financial, SISIP Services, PO Box 1030, 2727 Joseph Howe Drive, Halifax, NS B3J 2X5