Manulife

Group Benefits
Extended Health Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be provided for all expenses.
Please retain copies for your files as original receipts will not be returned.

1. Plan member information

Plan contract number: 28627 Plan member certificate number: _____

Plan sponsor: Peter Kiewit Sons ULC

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. Coordination of benefits

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

If **yes,** please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy): _____ Name of spouse's insurance company: _____

Spouse's plan contract number: _____ Spouse's plan member certificate number: _____

If Manulife is your secondary carrier, include copies of the receipts and the explanation of benefits from your primary carrier.

4. Patient information

Complete for all expenses. Use one line per patient.

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 aged 18 years or older. School and city	If employed, hours worked per week

5. Prescription drug expenses

- Include your prescription drug receipts with this form.
- All receipts must contain the drug identification number (DIN) and the name of the prescription drug.
- You are not required to list this information on the form.

6. Practitioner/ Paramedical expenses

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

For practitioner/paramedical expenses please include 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.

7. Equipment and appliance expenses

For equipment and appliance expenses Manulife 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/mmm/yyyy): _____ **To:** Date (dd/mmm/yyyy): _____

Has rental equipment been returned?: ◯ Yes ◯ No

Please complete next page.

8. Vision care expenses

Please enclose an itemized receipt indicating:

- patient name,
- cost of contact lenses,
- cost of glasses,
- cost of laser surgery,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- date dispensed.

To be completed by supplier:

If your contract covers medically necessary contact lenses, please answer the questions 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

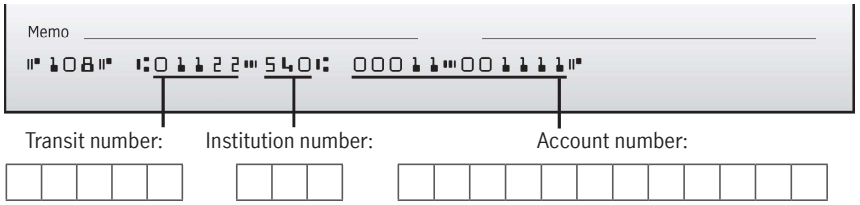
Signature of supplier: _____ Date signed (dd/mmm/yyyy): _____

9. Banking information and email address

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

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.

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.



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):

10. Claims confirmation

Total amount of **all** receipts submitted: $ _____ **Note - original receipts** must be provided for all expenses.

11. Authorization and consent

I confirm:
That the information in this form, and any further verbal or written statement provided by me to Manulife in the future is true, accurate and complete to the best of my knowledge.

I understand:

- That my claims and my coverage may be denied or terminated because I provided false, incomplete, or misleading information.
- That if Manulife determines a claim submission:
  – is incorrect, the claim will be corrected, and any overpayment will be recovered by Manulife;
  – is false or misrepresented, the claim will be reported, together with any related information/documentation to my plan sponsor, and any false claims may be referred to law enforcement authorities for possible prosecution.
- I am required to refund any money that I may owe to Manulife or my Plan Sponsor in accordance with the provisions of my Group Benefits plan and I authorize monies to be deducted from my future claims.

Privacy

I authorize:

- Manulife and/or its service providers, its reinsurers and their service providers to collect, use, maintain, and disclose my personal information relevant to this claim ("Personal Information") for the purposes of Group Benefits plan administration, audit, the assessment, investigation, and management of this claim, and/or other purposes identified in the Personal Information Statement for employers' Group Benefits plans (collectively, the "Purposes").
- Any person or organization who has Personal Information about me, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.
- The use of my Social Insurance Number ("SIN") for identification and administrative purposes, if my SIN is used as my plan member certificate number.

Continued on the next page.

11. Authorization and consent (continued)

I understand:

- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- A decision about my claim may be taken exclusively on the basis of an automated decision using my Personal Information.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. I may not withdraw my consent for Manulife to collect, use, or disclose Personal Information needed for my claim. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.

Requests can be sent to: **Privacy Officer Manulife, P.O. Box 1602, Del Station 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**

For more information, I can review the **Personal Information Statement for employers' Group Benefits plans** and the **Canadian Privacy Policy.**

I authorize Manulife to use the email address I provided as an additional means of communication about my file. I acknowledge correspondence by email may contain Personal Information including but not limited to sensitive information such as medical, employment and financial information. I understand that email communication is not yet a secure means of communication. I understand that I am responsible for updating the email address maintained by Manulife. I understand I can revoke the use of email address at any time by removing my email address online or contacting Manulife.

If applicable, I authorize Manulife to deposit all payments due to me from the above referenced Group Benefits policy ("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 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), as 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 or by representatives of my estate.

I understand that expenses reimbursed under the Health Care Spending Account may not be claimed for personal income tax purposes. I understand that should any tax consequences arise for reimbursement of these expenses, I am responsible for the payment of such taxes.

Please sign here: Signature of plan member: _____ Date signed (dd/mmm/yyyy): _____

12. Mailing instructions

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

Manulife Group Benefits
Health Claims
P.O. Box 2580, Station B
Montreal, Quebec H3B 5C6