Manulife Financial

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.*
- *Claims MUST be submitted to your provincial plan and THEN submitted to Manulife Financial with a copy of the statement of payment (or decline).*
- *Manulife Financial 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 FINANCIAL IS THE RESPONSIBILITY OF THE PLAN MEMBER.*

1 Plan member information

Plan contract number	**Division number**	**Plan member certificate number**	Plan sponsor

Plan member name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

HCSA contract number

◯ Check here to use your Health Care Spending Account (HCSA) to reimburse any unpaid portion of this claim.
(If the patient has health coverage under another plan, you **must** submit any unpaid amount from this claim to that plan **before** using your HCSA.)

2 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**

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

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.

Please complete page 2.

3 Claim information

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

Date of departure and return

Departure	Return	Province/country where treatment was provided
(dd/mmm/yyyy)	(dd/mmm/yyyy)	

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

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.

Additional comments regarding the Emergency Care claim:

4 Plan member confirmation

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **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. **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 or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Please sign here

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

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

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

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

5 Mailing instructions

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

MANULIFE FINANCIAL
GROUP HEALTH CLAIMS
PO BOX 1653
WATERLOO ON N2J 4W1