Manulife

Affinity Markets – 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 number _____ Identification Number _____

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/State _____ Postal code/Zip Code _____

2 Online Claims

Register for online claims today!

Submitting health and dental claims is now easier, faster and better.

On **Manulife.ca/SecureServe**, you can:

- Easily **submit claims online** – no more paper or snail mail
- Get **reimbursed up to 80% faster** with direct deposit – no more waiting for cheques
- See your **claims history and benefit eligibility**
- And **update your contact information**

Visit **Manulife.ca/SecureServe** to register.

3 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.

4 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 number _____ Identification Number _____

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

5 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)

6 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.

7 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.

8 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

9 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.

10 Claims confirmation

Total amount of ALL receipts submitted $_____

NOTE - ORIGINAL RECEIPTS must be provided for all expenses.

11 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 or co-applicant and/or my dependents have received all goods or services or qualify for benefits as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented may result in coverage being rescinded by Manulife without further notice. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution and may pursue the recovery of any money obtained improperly through false claim submission. **I also agree** to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of my coverage and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** any person or organization with information concerning me, my spouse or co-applicant and/or my dependents, 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 service providers, for the purposes of plan administration, audit and the assessment, investigation and management of this claim. **I agree** a photocopy; facsimile or electronic version of this authorization shall be as valid as the original.

PLEASE SIGN HERE

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

12 Statement of confidentiality

The specific and detailed information requested on the Extended Health Care Claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, PO BOX 1602, DEL STN 500-4-A, WATERLOO, ON N2J 4C6. A copy of our privacy policy is available on **manulife.ca.**

13 Mailing instructions

Please mail your completed claim form and receipts to:

Manulife Affinity Markets
Health Claims
P.O. Box 670, Stn Waterloo
Waterloo, ON N2J 4B8

14 Accessibility statement

Manulife is committed to offering products and services to persons with disabilities, in ways that are consistent with the principles of dignity, independence, integration and equal opportunity. Manulife has a core belief that everyone should be treated with courtesy and respect and made to feel welcome. Manulife's accessibility policy allows you to receive this form in alternate formats upon request. Please contact us at accessibilty@manulife.com, or call us at 1-855-891-8671, if you would prefer this document in an alternate format.

If you would like more details about accessibility at Manulife, we would encourage you to visit our website at **manulife.com/accessibility**.

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