

# STATEMENT OF CLAIM OUT-OF-COUNTRY EXPENSES

Please fully complete both sides of this form. Please Print.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Benefits for medical expenses incurred outside of Canada are subject to the coverage limitations in your group insurance plan, as well as payment by your provincial health plan and coordination with other insurance carriers. Completion of this claim form will allow us to pay eligible claims and coordinate benefits for your out-of-country medical expenses directly with your other insurance carriers on your behalf.

Please fully complete both sides of this statement of claim, including the "Statement of Other Insurance" shown on the reverse, and the attached government assignment form(s). Your claim cannot be considered unless this form is completed in full. Send these forms and all your original receipts to Great-West Life, Attention Out-Of-Country Claims Department, P.O. Box 6000, Winnipeg, Manitoba, Canada, R3C 3A5. Your receipts will be retained by Great-West Life. In-Canada expenses should be claimed separately. If you have any questions, please contact Great-West Life directly at 1-800-957-9777 and ask to speak to a client service representative in the Out-Of-Country Claims Department.

## GENERAL INFORMATION

Name of Employee \_\_\_\_\_

Complete Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Employer \_\_\_\_\_ Plan Number \_\_\_\_\_ I.D. Number \_\_\_\_\_

I authorize the release of any information or record(s) requested in respect of this claim to Great-West Life or its agents and certify that the information given herein is true, correct, and complete to the best of my knowledge.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

## PATIENT INFORMATION

Name of Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Purpose for Travelling \_\_\_\_\_

Date of Departure \_\_\_\_\_ Scheduled Return Date \_\_\_\_\_

Actual Return Date \_\_\_\_\_ Country Visited \_\_\_\_\_ Currency Used \_\_\_\_\_

Please provide a brief description of the illness/injury which required treatment outside Canada:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of initial onset of symptoms \_\_\_\_\_ 1st date you received medical attention for these symptoms \_\_\_\_\_

Prior to leaving Canada, was the patient aware of, or receiving treatment for this condition?  Yes  No

If yes, what was the last treatment date in Canada? \_\_\_\_\_

I authorize Great-West Life to make payment directly to the providers of the service.

Employee's Signature \_\_\_\_\_

## STATEMENT OF EXPENSES

Total number of invoices/bills included with this claim \_\_\_\_\_  
 Please itemize the expenses below. Attach a separate page if additional space is needed.

DATE	PROVIDER	AMOUNT
<b>TOTAL DOLLAR VALUE OF BILLS SUBMITTED</b>		<b>\$</b>

## STATEMENT OF OTHER INSURANCE

Are you or any other member of your immediate family entitled to travel and/or medical insurance benefits under any other policy, including other group coverage through employment, individual/private travel plans, or credit card plans.

YES     NO

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

<b>Type of other Coverage:</b> (group, individual, credit card)	<b>Name and phone number of Other Carrier:</b>
<b>Policy or Plan Number:</b>	<b>I.D. Number:</b>

Have you sent a claim and/or otherwise contacted the other carrier about this claim?    YES     NO

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before any benefits can be paid.

I \_\_\_\_\_ (signature) hereby authorize Great-West Life and it's agents to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Great-West Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Great-West Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.