Manulife Financial

Affinity Markets
Extended Health Care Claim

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 Plan member information

Plan number	**Identification number**	Telephone number ( )

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

Plan member address (number, street and apt.)	City or town	Province	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 "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 no.	Spouse's certificate no.

2 Patient information

Complete for all expenses. Use one line per patient.

			Complete if patient is a student 18 or older	
Patient's name	**Date of birth** (dd/mmm/yyyy)	**Relationship to plan member**	**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.), the name of the prescription drug, strength and quantity.
- 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.

Please complete page 2.

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/mmm/yyyy) **To** Date (dd/mmm/yyyy)

Has rental equipment been returned? ◯ Yes ◯ No

6 Vision care expenses

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.

7 Claims confirmation

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.

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, any type of workers' compensation board and investigative agencies, to release and exchange such information requested by Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.
I authorize Manulife Financial and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any 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.
If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my benefits.
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/mmm/yyyy)

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in an Affinity Markets Life and Health Benefits file. Access to your information will be limited to:

- our employees and service representatives 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, if necessary, correct any inaccurate information.

8 Mailing instructions

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

Manulife Financial Affinity Markets
Health Claims
PO BOX 4214, STATION A
TORONTO ON M5W 5M4

Telephone: 1-800-COVER ME® (1-800-268-3763)

Manulife Financial will not assume responsibility for any fees associated with the completion of this form.