Manulife

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 statement

Plan number	Identification number

Plan member name (first, middle initial, last)

Address (number, street and apt.)	City/Town

Province/State	Postal/Zip code	Country	Telephone number
			( )

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 number	Spouse's certificate number

2 Patient information

Complete for all expenses.
Use one line per patient.

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member	Amount of expense	Complete if patient is a student 18 or older: School City Province/State	Complete if patient is a student 18 or older: 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 (DIN), the name of the prescription drug, strength and quantity.
- You are not required to list this information on the form.

4 Practitioner/ Paramedical expenses

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

For practitioner/paramedical expenses please attach an **itemized 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.

Was patient referred by a physician? ◯ Yes ◯ No

Please complete next page.

5 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

6 Vision care expenses

Please enclose an original itemized receipt issued by a supplier indicating:

- patient's name,
- cost of contact lenses,
- date dispensed.
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- treatment,

Preferred Vision Services (PVS)

Did you know you can take advantage of discounts available through a specific network of retailers and providers across Canada using our Preferred Vision Services (**PVS**)?
You can save up to 20% on eyewear purchases made at participating optical retailers, which includes lenses, frames and contact lenses, depending on where you shop.
Visit **pvs.ca** for more details and start saving today.

7 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

RESET

Save As

Print

Please sign here.

Total amount of ALL receipts submitted $ 0.00 ◯ CAD ◯ USD

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** The Manufacturers Life Insurance Company (Manulife Financial) to collect, use, maintain, and disclose personal information relevant to this claim ("Information") for the purposes of 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, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife Financial, its reinsurers and/or its service providers, for the Purposes. **I agree** a photocopy or electronic version of this authorization is valid.

Plan member signature | Date signed (dd/mmm/yyyy)

8 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 Financial) 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 Financial 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 Financial 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 principles and practices is available for view at **manulife.ca**.

9 Mailing instructions

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

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

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

10 We're here to help!

manulife.ca/affinityforms to print out additional copies of the Extended Health Care Claim Form

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