THE **Great-West Life** ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested. Note: Bills and receipts, other than those required for government plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.

Please print

PART 1: CLAIMANT'S STATEMENT

PLAN NUMBER	PLAN NAME
51582	**TORONTO TRANSIT COMMISSION**

CLAIMANT IDENTIFICATION NUMBER	CLAIMANT NAME	DATE OF BIRTH Year Month Day

ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE	PHONE # HOME:	WORK:

COORDINATION OF BENEFITS:

Are you or any other member of your family entitled to benefits under any other plan?

☐ Yes ☐ No

If "Yes", name of family member insured _____

Relationship to claimant _____

Name of other insurance company _____

Policy Number _____

Is any member of your family (other than yourself) insured as an claimant under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's

date of birth _____ / _____
Day Month

Is treatment required as the result of an accident? ☐ Yes ☐ No If "Yes", give date, location

and explain how accident happened _____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

SEND THIS CLAIM TO:

Great-West Life Health & Dental Benefits
P.O. Box 4076 Stn A
Toronto ON M5W 3A3
1-800-874-5899
(416) 440-0406

DEPENDENT INFORMATION

If the child is between 21-25 years, effective January 1, 2003

Patient Name	Relationship to Claimant	Date of Birth Year	Mth	Day	Does patient reside with you? YES	NO	Full-Time Student? YES	NO	If Student, how many hours per week?	Employed? YES	NO	How many hours worked per week?
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					☐	☐	☐	☐		☐	☐	
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					☐	☐	☐	☐		☐	☐	

CLAIM DETAILS

Patient Name	OTHER EXPENSES Type of Expense	Nature of Illness	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I hereby certify that the above information is complete and accurate and that all of the expenses were for services and supplies received by me and/or my eligible dependents. I authorize the release of information relating to the expenses on this form.

SIGNATURE OF CLAIMANT _____ DATE _____