THE Great-West Life ASSURANCE COMPANY

STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Great-West Life
your Benefits Solutions People

Please fully complete both sides of this form. Please Print. When submitting, be sure to attach the required provincial forms available by visiting www.greatwestlife.com or calling our client services at 1-800-957-9777.

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

Benefits for medial 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 coordinate benefits with other insurance carriers. Completion of **these** claim forms 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.

Your claim cannot be considered unless the above mentioned forms have been completed and returned to us along with all your original receipts. Please return all required forms 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 the client service representative in the Out-of-Country Claims Department.

GENERAL INFORMATION

Name of Employee _____

Complete Mailing Address _____

_____ Phone Number _____

Employer **CARLETON UNIVERSITY** Plan Number **51801** 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 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
	TOTAL DOLLAR VALUE OF BILLS SUBMITTED	**$**

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:

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

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 _____ *hereby authorize Great-West Life and it's agents to*
(signature)
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.