

Claim form

Medical and paramedical

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Policy no.			Certif	icat	e no.								РО		00, P	ost ST bec +		טער	
Policyholder nai	me												Tor	onto			, טכו	כאכ	
Participant surn	iame							Given nam	ne(s)		Initial				0ntai	io Ma	2M 4	К3	
Main residence	address (no	o., street)							Apt.	Postal code									
City								Province		Telephone no. (day)		Ρĺ		print,	ensur			
Language \Box	English	☐ French			Gen	dor	_] M 🔲	Date of birth				si	gn th	s forn	s prov n in or ssing	der	to av	
Language L	Linguisii	- Helicii			dem	uci							lf	you n	eed a	ssilig ssista nis for	nce	in	
Dependents															itate 1 99-4	to con 415 .	tact	us a	t
		he first tim	e you	น รเ	ubmit	t a cl	laim		pendent child or spouse	or whenever t	there is a change.								
Spouse surname	е							Given i	name(s)										
Date of birth																			
Children																			
Complete name	e	Date of	oirth			Gei	nder F	Full-time student ¹	Confirmation of school at Name of educational inst		ndance period				n t's st andard	atus: I Life <i>A</i>	Assui	rance	.
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Coordination	of bene	fits														essed se sul			
Complete this	s section i	if any expe	nses	s yo	u are	cla	imin	g for are	covered by another pla	an.²			of	their	expla	natio f rece	n of	bene	
Name of your spo	ouse's group	o insurer							Policy no.				_						
Certificate no.								Coverag	ge: Health care	Single	☐ Family		DL						
									Dental care	Single	☐ Family				ee rev				
Effective date of c of benefits	coordination								ation date of coordination fits (if applicable)							eed tl e deta			ing
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Direct dense	it suth	evization																	
Direct depos			n aum	ont	hu Cta	ndar	4 I :£4	. Dlagga ga	umplote this section only if y	ou have never pr	ovided Standard Life v	uith v	10.11E	bank	ing in	o rm a	tion		
What is the reaso	on for compl	leting this fo	m?	1 ent	by Sta st requ	ındar Jest		Modificatio	omplete this section only if y on Policy no.	ou nave never pro	Certificate no.	with y	our/	bank	ing ini	orma	tion.		
Participant surn	ame						Giv	ven name		Initial	Telephone	no. (day)						
Financial institu	ition name							Financ	cial institution address										
Please complete	this section	n or attach a i	persor	naliz	zed vo	id ch	eque	to ensure t	that we obtain your accurate	banking informa	ation.								
Branch no.						ln:	stitut	tion no.		Account no	0.								
									ntioned on this form. I certify t may be cancelled at any tin							d I agr	ree to	0	
Participant sign	ature										Date		Υ						
Account holder	signature (if	f other than p	artici	pant	t)						Date								
For Standard Life	e use only										Received								
TOT STRUCTED LIFE	e use only										keceived								

Medical expenses								
Drugs: The receipts must show patient name, drug name and drug identification number (DIN).	Total amount of your drug claims The claims expenses must be							
Other medical and paramedical expenses: Receipts should indicate the provider raddress, and all dates of visits or any exams and detailed related costs. Always re booklet to confirm coverage for different health practitioners and attach physician where required by your contract.	efer to your other medical and a claim until incurred expenses							
Vision care: Receipts must indicate the provider name and address, and show sep costs for contact lenses, frames and lenses for glasses, cost and date of eye exam	parate Total amount of your vision \$500, please submit an estima in writing first to verify eligibilit							
Out of country: Claims for all medical expenses, except drugs, must first be sent t forwarded to Standard Life with provincial proof of payment and copies of all rece provider specialty, name, address and telephone number. Reason for travel	\$ Attach original receipts and keep copies for your records. A receipts and elipts. All receipts must show days. The statement of benefits and copies of your receipts are							
Date of departure	sufficient for income tax and benefit coordination purposes.							
In what country were the expenses incurred?								
Are these expenses covered under a travel insurance or other plan? Were expenses incurred due to an emergency?	Yes No							
Plan with Health Spending Account (if applicable)								
Do you want any unpaid portion of this claim to be considered under your Health Spending Account?*	☐ Yes ☐ No Note:							
Accident	* If your Health Spending Account provides for automa							
If the accident involves dental injury, please complete G2019. Please describe the accident	reimbursement, any unpaid portion will be paid from you Health Spending Account, subject to remaining credits.							
	The coordination of benefits guidelines will apply.							
Has any portion of these expenses been submitted to a government body for								
reimbursement (WSIB, CSST,)?	☐ Yes ☐ No							
Authorization								
I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan or organization in possession of information concerning myself to release to The Standard Life Assura financial, or other information deemed relevant by Standard Life, for the assessment of my claim. I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations re my claim. I accept that Standard Life or their authorized agents use the information provided in this for (if relevant) for the management of my claim and for statistical reports. I confirm being authorized by my dependents to act on their behalf for their expenses submitted in this consent to the use of my social insurance number as my certificate number, and understand that it is employer/plan administrator if I prefer to use another identification number.	ance Company of Canada all medical, required in order to verify the validity of orm and prior claims under the same plan nis claim.							
I certify that the information contained in this form is true, correct and complete and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life will automatically reject this claim in all or in part.								
A photocopy of this authorization is valid as the original. Participant signature Da	ate Y Y Y M M D D							

www.standardlife.ca

The Standard Life Assurance Company of Canada

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