

**HEALTHCARE EXPENSES STATEMENT**

SEND THIS CLAIM TO:

Regina Benefit Payments  
P.O. Box 4408  
Regina SK S4P 3W7  
English: 1-866-289-5675 French: 1-866-814-6503  
For the deaf or hard of hearing:  
Toll Free: 1-800-990-6654  
Or: (204) 946-7281

**INSTRUCTIONS:** Attach the bills and receipts for all expenses and itemize them by providing all the information requested.

Note: Drug bills and receipts, other than those required for government drug 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. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

PART 1 EMPLOYEE INFORMATION					
PLAN NUMBER <b>164033</b>	DIVISION NUMBER	PLAN NAME <b>Flint Energy Services Ltd.</b>			
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME			DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET		TOWN	PROVINCE	POSTAL CODE	PHONE #
		HOME:		WORK:	

DO YOU WANT ANY UNPAID PORTION OF YOUR CLAIM PROCESSED THROUGH YOUR HEALTHCARE SPENDING ACCOUNT?  YES  NO  
IF CLAIMING FOR REIMBURSEMENT FROM THE HEALTHCARE SPENDING ACCOUNT, ARE YOU ENTITLED TO CLAIM A MEDICAL EXPENSE TAX CREDIT UNDER THE INCOME TAX ACT (CANADA) FOR THE PATIENT?  YES  NO

PART 2 COORDINATION OF BENEFITS	
Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member insured _____ Relationship to employee _____	
Name of other insurance company _____ Policy Number _____	
Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member _____	
If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Year / Month / Day)	
Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date, location and explain how accident happened _____	
Is a claim being made for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 3 DEPENDENT INFORMATION							If child over 18 years				
Patient Name	Relationship to Employee	Date of Birth			Does patient reside with you?		Full-Time Student?	If student, how many hours per week?	Employed?		How many hours worked per week?
		Year	Month	Day	YES	NO			YES	NO	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

PART 4 CLAIM DETAILS (If additional space is needed, attach a separate page)			OTHER EXPENSES		
DRUG EXPENSES			Type of Expense	Nature of Illness	Total Charge
Patient Name	Number of Receipts	Total Charge			

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 authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_