MAIL TO: Group Operation
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

Extended Health Benefit /Vision Claim Form

CLAIMING INSTRUCTIONS

1. *This form is to be completed by the Plan Member. Time limit is 365 days.*
2. *Original receipts/invoices must be attached for all expenses.*
3. *The original receipts/invoices will not be returned.*
4. *Please retain copies of all documents for your records.*
5. *A fee will be charged for copies of claim documents.*

EMPLOYEE STATEMENT

Group Number: **G** | Employer Name: | Certificate Number: **WLI**

Employee Name: _____

Complete this section if this is your first claim or if your address has changed since your last claim. Our records will be updated.

Home Address: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

1. Are you, your spouse or dependents eligible for the claimed expenses under any other plan? ☐ Yes ☐ NO

If YES, name of other carrier _____ Spouse's Name _____ Spouse's Date of Birth(YY/MM/DD) _____

Effective Date of Coordination of Benefits (YY/MM/DD) _____ Termination Date of Coordination of Benefits (YY/MM/DD) _____

(attach copy of statement of payment or denial from other carrier)

2. Is claim being filed with Worker's Compensation or Auto Insurer? ☐ YES ☐ NO

3. Are the claimed expenses eligible under your Provincial Health Plan? ☐ YES ☐ NO

If YES, have you attached a copy of their payment or denial? ☐ YES ☐ NO

4. Are you claiming for medical equipment or appliances? ☐ YES ☐ NO

If YES, please provide the following information:

(a) Physician's referral prescription

(b) The number of hours per day the item is intended to be used: ____

(c) What activities the equipment is intended for: _____

PRESCRIPTION, DRUGS AND OTHER MEDICAL EXPENSES (PLEASE ATTACH ORIGINAL RECEIPTS)

COMPLETE THIS SECTION FOR DRUGS, VISION, PARAMEDICAL, HOSPITAL AND ALL OTHER MEDICAL EXPENSES

Please complete for all patients with expenses:

NAME	SEX	BIRTHDATE YY/MM/DD	RELATIONSHIP	TYPE OF EXPENSE	NUMBER OF RECEIPTS	TOTAL AMOUNT CLAIMED FOR EACH PATIENT
					TOTAL AMOUNT CLAIMED	

EMPLOYEE AUTHORIZATION

Notice Concerning Personal Information

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintain communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400 – 200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

Authorization

I have read the above Notice Concerning Personal Information. I authorize the release of any information in respect of this claim to Wawanesa Life. I further certify that the information on this form is true and complete.

_____ Employee Signature _____ Date

For Wawanesa Life Head Office Use Only