Manulife

Group Benefits
Out-of-province/Out-of-Canada Health Claim
(for physician's fees and hospital services only)

- To be completed by the plan member unless otherwise indicated.
- One form must be completed for each patient.
- Manulife will coordinate claim assessments on your behalf when you have individual travel health insurance coverage.
- Please attach copies of itemized statements from the provider of services to the **back** of this form. These will not be returned.
- Eligible expenses submitted in a foreign currency will be paid in Canadian funds.
- **Any costs incurred as a result of obtaining any additional information that is required by Manulife is the responsibility of the plan member.**

1 Plan member information

Plan contract number: | Plan member certificate number:

Plan sponsor:

Plan member name (first, middle initial, last):

Date of birth (dd/mmm/yyyy): | Daytime phone number: ( )

Plan member address (number, street, and apt.):

City/Town: | Province: | Postal code:

2 Workers' compensation board

Are any of the expenses associated with a work related incident **and** eligible for workers' compensation benefits? ◯ Yes ◯ No

If **yes**, submit these expenses to your provincial workers' compensation board.

3 Patient information

Complete for all expenses.

Complete if patient is a student aged 18 years or older.

Patient's name	Date of birth (dd/mmm/yyyy) (1st Claim only)	Relationship to plan member (1st Claim only)	School and city	If employed, hours worked per week

Important: Claims must be submitted to your provincial plan and then submitted to Manulife with a copy of the statement of payment (or decline).

Is the patient covered under any other travel or group insurance plan for the expenses being claimed? ◯ Yes ◯ No

If **yes**, please provide the following information:

Name and address of insurance company	Type of policy	Plan contract number	Plan member certificate number	Name of person(s) policy issued to
1	◯ Ind.* ◯ Group**			
2	◯ Ind.* ◯ Group**			
3	◯ Ind.* ◯ Group**			
4	◯ Ind.* ◯ Group**			

* **"Ind."** refers to travel insurance purchased by the individual/family. ** **"Group"** refers to benefits provided through plan sponsor.

4 Claim information

Date of departure (dd/mmm/yyyy): | Date of return (dd/mmm/yyyy): | Province/country where treatment was provided:

1. Describe when, how, and where the injury/illness occurred.

Please complete next page.

GL3189E (12/2024) CII

4 Claim information (continued)

Emergency care treatment for an injury which occurs or an illness which begins while temporarily outside of province/Canada.

2. Was the patient previously treated for this condition any time prior to leaving province/Canada? ◯ Yes ◯ No

If **yes**, please attach a letter from the treating Canadian physician stating the previous treatment rendered.

3. Did you receive a discount from the provider of service for any of the bills/invoices submitted? ◯ Yes ◯ No

If **yes**, please submit original discounted bills/invoices for processing.

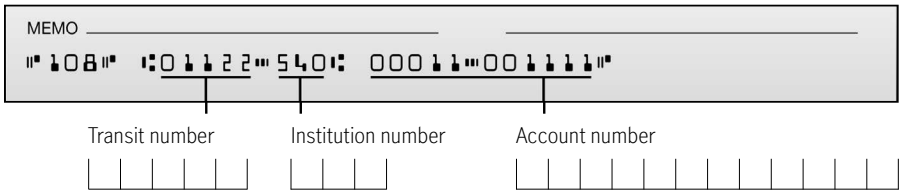
Additional comments regarding the Emergency Care claim:

5 Banking information and email address

Complete **only** when providing new or updated information.

Visit **manulife.ca/planmember** to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile menu **or** complete this section.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.



By providing your email address, you will receive an email notification once your claim has been processed, including a link to **manulife.ca**, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit **manulife.ca/planmember** to register for your Plan Member secure site.

Email address (Please print clearly)

6 Authorization and consent

I confirm:

That the information in this form, and any further verbal or written statement provided by me to Manulife in the future is true, accurate, and complete to the best of my knowledge.

I understand:

- That my claims and my coverage may be denied or terminated because I provided false, incomplete, or misleading information.
- That if Manulife determines a claim submission:
  - is incorrect, the claim will be corrected, and any overpayment will be recovered by Manulife;
  - is false or misrepresented, the claim will be reported, together with any related information/documentation to my plan sponsor, and any false claims may be referred to law enforcement authorities for possible prosecution.
- I am required to refund any money that I may owe to Manulife or my Plan Sponsor in accordance with the provisions of my Group Benefits plan and I authorize monies to be deducted from my future claims.

Privacy

I authorize:

- Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain, and disclose my personal information relevant to this claim ("Personal Information") for the purposes of Group Benefits plan administration, audit, the assessment, investigation, and management of this claim, and/or other purposes identified in the Personal Information Statement for employers' Group Benefits plans (collectively, the "Purposes").
- Any person or organization who has Personal Information about me, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose, and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.
- The use of my Social Insurance Number ("SIN") for identification and administrative purposes, if my SIN is used as my plan member certificate number.

I understand:

- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers, and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- A decision about my claim may be taken exclusively on the basis of an automated decision using my Personal Information.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. I may not withdraw my consent for Manulife to collect, use, or disclose Personal Information needed for my claim. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind, or terminate my claim.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.

Requests can be sent to: **Privacy Officer Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6** or **Canada_Privacy@manulife.ca**.

For more information, I can review the **Personal Information Statement for employers' Group Benefits plans** and the **Canadian Privacy Policy**.

I authorize Manulife to use the email address I provided as an additional means of communication about my file. I acknowledge correspondence by email may contain Personal Information including but not limited to sensitive information such as medical, employment, and financial information. I understand that email communication is not yet a secure means of communication. I understand that I am responsible for updating the email address maintained by Manulife. I understand I can revoke the use of email address at any time by removing my email address online or contacting Manulife.

6 Authorization and consent (continued)

If applicable, I authorize Manulife to deposit all payments due to me from the above referenced Group Benefits policy ("Payments") into the bank account ("Account") that I have identified on this form. I confirm that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). I also understand and agree that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s), as requested herein, and require my personal written endorsement relating to future Payment(s). I also hereby acknowledge and agree that any Payment(s) made by Manulife into the Account, to which I am not entitled, either by contract or by law, shall not form part of my property, and shall be immediately refunded to Manulife, either by me or by representatives of my estate.

I understand that expenses reimbursed under the Health Care Spending Account may not be claimed for personal income tax purposes. I understand that should any tax consequences arise for reimbursement of these expenses, I am responsible for the payment of such taxes.

Please sign here

Signature of plan member:	Date signed (dd/mmm/yyyy):

7 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Group Benefits
Health and Dental Claims, 500 G-B
500 King St N
Waterloo ON N2J 4C6

If you live in Quebec:
Manulife Group Benefits
Health Claims and Dental Claims
2000 Mansfield St
Montreal QC H3A 2Y9

Print

Reset

Manulife