STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Please complete both sides of this form and mail to Canada Life, Attention: Out-of-Country Claims Department PO Box 6000 Winnipeg MB R3C 3A5.

When submitting your claim, be sure to attach the required provincial forms available to you by visiting www.canadalife.com or by calling our Out-of-Country Claims Department at 1-800-957-9777 .

Completion of **these** forms will allow us to pay eligible claims and coordinate payment directly with your provincial health plan or with any other insurance carriers.

GENERAL INFORMATION

Name of Employee _____

Complete Mailing Address _____

Phone Number _____ E-mail Address _____

Employer IATSE Local 891 Employee Life and Health Trust Plan Number 58197 I.D. Number _____

I authorize the release of any information or record(s) requested in respect of this claim to Canada 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 Canada 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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I authorize Canada 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 Canada Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life to make payment directly to the providers of the service.

Employee's Signature _____

canada life™

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	$ 0.00

STATEMENT OF PROVINCIAL HEALTHCARE COVERAGE

1. Is the patient covered under their provincial healthcare plan? ☐ **YES** ☐ **NO**

2. Please ensure you complete the provincial authorization form(s) available at www.canadalife.com.

STATEMENT OF OTHER INSURANCE

1. Are you or any member of your family, entitled to insurance under any other plan for the expenses being claimed? ☐ **YES** ☐ **NO**
2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child
   First Name _____ Last Name _____
3. If the patient is a dependent child, please provide spouse's date of birth. (Day/Month) _____
4. Is the other insurance also with Canada Life? ☐ **YES** ☐ **NO**
   If yes, please provide Canada Life Plan Number _____ ID 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 Canada Life and its 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 Canada Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Canada Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.

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