

# Family-Building Expenses Statement

## INSTRUCTIONS

Use this form to submit expenses under your Family-Building benefit, such as fertility and surrogacy related expenses. If the expenses you are claiming are in relation to a surrogacy arrangement and this is your first time claiming surrogacy related expenses, we require a copy of the surrogacy contract. Please submit a copy of the contract with your claim.

1. Complete page 1 and 2 of this form in full.
2. Please review and sign the form.
3. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
4. Send to the appropriate Benefit Payment Office for your plan. See PART 6.

**THIS IS A:**  Claim for benefits  Pretreatment/estimate

## PART 1 – Privacy Consent, Certification, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been provided in Canada and received by me, my dependants and/or surrogate; and that my dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

*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. I authorize Canada Life, any healthcare or dentalcare 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.*

*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](http://www.canadalife.com).*

Plan member signature X _____	<b>Date</b>	Day	Month	Year
Surrogate signature (if applicable) X _____	<b>Date</b>	Day	Month	Year

## PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name			
Plan number	Plan member I.D. number		
<b>Plan member name</b>			
First name	Last name		
<b>Plan member address</b>			
Number and street	City or town	Province	Postal Code
<b>Date of birth</b>	Day	Month	Year
<b>Language preference</b>			
<input type="checkbox"/> English <input type="checkbox"/> French			

# Family-Building Expenses Statement

**PART 3 – Coordination of benefits** - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

- Are you, or any member of your family, entitled to insurance under any other plan for the expenses being claimed?  Yes  No  
If "Yes", please answer the questions below.
- Who does the other insurance belong to?  Self  Spouse  Child  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
- If the patient is a dependant child, please provide spouse's date of birth: Day  Month
- Is the other insurance also with Canada Life?  Yes  No\*  
If yes, please provide: Canada Life plan number: \_\_\_\_\_ ID Number: \_\_\_\_\_  
\*If the other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach the other insurer Explanation of Benefits (EOB) to this claim. An EOB is required even if no benefits were paid by the other insurance.

**PART 4 – Patient information** - Complete for all expenses; one line per patient.

Patient name First name/Last name	Patient's relationship to plan member				Patient's date of birth			If child over 18 years			Does patient reside with plan member?		
								Full time student		If employed, how many hours worked per week?			
	Self	Child	Spouse	Surrogate	Day	Month	Year	Hours per week	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"/>					<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 5 – Claim details** - If additional space is needed, attach a separate page.  
If the expenses you are claiming are in relation to a surrogacy arrangement and this is your first time claiming surrogacy related expenses, we require a copy of the surrogacy contract. Please submit a copy of the contract with your claim.

Patient name - First name/Last name	Type of expense

**PART 6 – Submitting your claim**

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free:



**Deaf or hard of hearing and require access to a telecommunications relay service?**

Please contact us:

TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

[www.canadalife.com](http://www.canadalife.com)