MAIL TO: WAWANESA LIFE
GROUP DIVISION
702-191 BROADWAY
WINNIPEG, MANITOBA
R3C 3P1
1-800-665-7076

Wawanesa Life

GROUP EXTENDED HEALTH BENEFIT / VISION CLAIM FORM

CLAIMING INSTRUCTIONS

1. THIS FORM IS TO BE COMPLETED BY THE PLAN MEMBER.
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.

PART 1 EMPLOYEE STATEMENT

GROUP NUMBER	EMPLOYER NAME	CERTIFICATE NUMBER

NAME _____

ADDRESS _____
(Street) (City) (Prov.) (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 _____
(ATTACH COPY OF STATEMENT OF PAYMENT OR DENIAL FROM OTHER CARRIER) (YY/MM/DD)

2. IS CLAIM BEING FILED WITH WORKER'S COMPENSATION or AUTO INSURER? YES ☐ NO ☐

PART 2 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 maintaining 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 200-191 Broadway, Winnipeg, MB R3C 3P1 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 _____

PART 3 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		$

PART 4 ADDITIONAL CLAIM INFORMATION

PLEASE READ THIS SECTION CAREFULLY. FAILURE TO COMPLETE THIS SECTION MAY RESULT IN A DELAY IN THE PROCESSING OF YOUR CLAIM.

1. If claiming expenses which are eligible under your Provincial Health Plan, have you attached a copy of their payment or denial? Y / N

2. If claiming for the services of a practitioner, have you provided the practitioner's name, qualifications and license number? Y / N

3. If claiming for medical equipment or appliances, have you attached a copy of the physician's recommendation? Y / N

4. If claiming for medical equipment or appliances, please provide the following information:
a) Please advise the number of hours per day the item is intended to be used: _____
b) Please advise what activity (or activities) the equipment is intended for: _____