

## Group Benefits Extended Health Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

**Note: Prescription drug receipts must indicate a Prescription Number, Drug Identification Number (DIN) and brand name.**

### 1 Plan member information

Plan no. <b>84444</b>	Div. no.	Employee number	Plan sponsor <b>Toronto District School Board</b>	
Plan member name (first, middle initial, last)				Birthdate (dd/mmm/yyyy)
Plan member address (number, street and apt.)		City or town	Province	Postal code
Mailing address, if different (no., street, apt., dept. name and floor)*		City or town	Province	Postal code

\* Please provide a mailing address for this claim.

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

Yes  No

If "Yes," please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan no.	Spouse's certificate no.
--------------------------------------	------------------------------------	-------------------	--------------------------

**Please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier.**

Are any expenses incurred as a result of an accident?  Yes  No If yes, specify:

Date of accident (dd/mmm/yyyy)	Patient's name	Details
--------------------------------	----------------	---------

Please provide additional accident details on a separate sheet if insufficient space available.

Are these expenses eligible for coverage under any type of workers' compensation board?  Yes  No

### 2 Patient information

Complete for all expenses. Use one line per patient. Attach list if insufficient space available.

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to plan member	For each patient, show only date of first and last bill		Total dollar amount (\$)
			From	To	

### Additional child information

Complete only if patients listed above include dependent children.

Child's name	Student		Handicapped		Name of School
	Yes	No	Yes	No	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

### 3 Plan member confirmation

I CERTIFY that the foregoing answers and the information contained in other documents supporting this claim for benefits are, to the best of my knowledge and belief, true, full and complete. Wilful misrepresentation could be considered fraud and subject to penalties.

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

### 4 Mailing instructions

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

MANULIFE FINANCIAL  
GROUP BENEFITS  
PO BOX 1658  
WATERLOO ON N2J 4W6