

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.
All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

EMPLOYEE INFORMATION			
PLAN NUMBER 163285	PLAN NAME MERIT CONTRACTORS ASSOCIATION - RETIREE BENEFIT PLAN		
MEMBER IDENTIFICATION NUMBER	EMPLOYEE NAME		DATE OF BIRTH Year Month Day
ADDRESS: NUMBER AND STREET	TOWN	PROVINCE	POSTAL CODE

COORDINATION OF BENEFITS	SEND THIS CLAIM TO:
<p>Are you entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of other insurance company _____</p> <p>Policy Number _____</p> <p>Is your spouse entitled to benefits under any other plan or as a retiree under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes". Name of other insurance company _____</p> <p>Policy number _____</p> <p>Is treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give date, location and explain how accident happened _____</p>	<p>Winnipeg Benefit Payments P.O. Box 3050 Winnipeg MB R3C 0E6</p> <p>If you require assistance or have questions about your claim, please contact Mercon Benefit Services at: 1.877.263.7266 (780.455.5845 in Edmonton).</p>

CLAIM DETAILS	DRUG EXPENSES		OTHER EXPENSES		
	Patient Name	Number of Receipts	Total Charge	Type of Expense	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

At Great-West 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West 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 Great-West 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.

EMPLOYEE'S SIGNATURE _____ **DATE** _____