

Group Benefits

Supplementary Health and Hospital Insurance Claim

Province of Ontario Employee's Group Insurance Plan

1. Drug receipts filed using this claim process must show either the name of the drug or the drug identification number (D.I.N.)
 2. Claims will NOT be honoured later than the end of the calendar year following the year in which the expense was incurred. If you terminate coverage due to resignation, transfer out of OPSEU, retirement or death, claims must be submitted **within 90 days of date of termination**. Termination of coverage also applies to seasonal employees and employees who are on an approved and unpaid leave of absence and who do not elect to pay benefit premiums.
 3. If you are unsure about coverage for a particular expense, please call Manulife Financial directly at **1-800-268-6195**.
- Please retain copies for your files as original receipts will not be returned.**

1 Employee information	Plan no. 15900		WIN ID no.		Plan sponsor Province of Ontario				
	Employee name (first, middle initial, last)					Birthdate (dd/mmm/yyyy)			
	Employee 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	
	Are you, your spouse or dependents covered under any other plan for the expenses being claimed? <input type="radio"/> Yes <input type="radio"/> No If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:								
	Spouse's date of birth (dd/mmm/yyyy)			Spouse's name (first, middle initial, last)					
Name of spouse's insurance company					Spouse's certificate no.		Spouse's plan no.		
Are any expenses incurred as a result of an accident? <input type="radio"/> Yes <input type="radio"/> 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.

2 Banking information for direct deposit Electronic claim statements	To have this and all future claims payments deposited directly into your bank account, attach a void cheque to this claim form and indicate "Yes," in the box below. <input type="radio"/> Yes, I have attached a void cheque and would like all my future claims payments deposited into this account.	
	To have this and all future claims statements sent to you electronically, you must register to the Plan Member Secure Site. Log on to www.manulife.ca/groupbenefits for more information.	

Patient's name	Date of birth (dd/mmm/yyyy)	Relationship to employee	Drugs	Other medical expenses e.g. eye glasses, hearing aids, chiropractor, orthotics	Disabled dependent?		If age 21 or over, full-time student?	
					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"/>

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

4 Employee authorizations and declaration	I authorize the release of any information or records requested in respect of this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge. I authorize the use of my WIN ID number for the purpose of tax reporting and if my WIN ID number is used as my certificate number, I authorize its use for the identification and administration of my group benefits. At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to: <ul style="list-style-type: none"> • Our employees and representatives in the performance of their jobs; • Persons to whom you have granted access; and • Persons authorized by law. 	
	Signature of employee _____ Date (dd/mmm/yyyy) _____	

5 Mailing instructions Please mail your completed claim form and receipts to the address shown.	MANULIFE FINANCIAL GROUP BENEFITS PO BOX 1657 WATERLOO ON N2J 4W5 1-800-268-6195
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