

SEND THIS CLAIM TO:

INSTRUCTIONS: Complete a separate form for each family member for whom you are claiming expenses. Attach bills for each expense and fully itemize them in the space provided below.

IMPORTANT: If any of the requested information is missing or incorrect, your claim will be returned. 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

PART 1 EMPLOYEE INFORMATION

| | | | | | |
|--------------------------------|-----------------|--|----------|-------------|---------------------------------------|
| PLAN NUMBER 160436 | DIVISION NUMBER | PLAN NAME Transco Energy Services Ltd | | | |
| EMPLOYEE IDENTIFICATION NUMBER | | EMPLOYEE NAME | | | DATE OF BIRTH (Year / Month / Day) |
| ADDRESS: NUMBER AND STREET | | TOWN | PROVINCE | POSTAL CODE | PHONE # |
| | | | | HOME: | WORK: |

PART 2 PATIENT INFORMATION

| | | | |
|---|--|--------------------------|---------------------------------------|
| PATIENT NAME | | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH (Year / Month / Day) |
| If Dependent, does the patient reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If child 18 years or older: a) Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week at school? _____ | | | |
| b) Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week? _____ | | | |

PART 3 COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? Yes No

If yes, name of family member insured _____ Relationship to employee _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than yourself) insured as an employee under this plan? Yes No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____
(Day / Month / Year)

PART 4 TO BE COMPLETED BY PROVIDER OF MATERIALS

| | | |
|---|-------------------------|------------------------------------|
| Date of Service _____ | Type of lenses supplied | Reason for purchase (please check) |
| Frames \$ _____ | Left Eye | a) Initial prescription _____ |
| CHARGES FOR Lens for right eye \$ _____ | Right Eye | b) Prescription change _____ |
| MATERIALS Lens for left eye \$ _____ | Plain glass _____ | c) Loss or breakage _____ |
| SUPPLIED Other \$ _____ | Single vision _____ | d) Other (please explain) _____ |
| TOTAL \$ _____ | Bifocal _____ | |
| | Trifocal _____ | |
| | Contact _____ | |

Give reasons and specific item cost for "Other" in area 1 (e.g. hardening, tinting, varigray, oversize lenses, etc.)

If glasses tinted, what was tint?

Name of Prescribing Optometrist or Ophthalmologist - if signed by Optician

I am a legally qualified Ophthalmologist Optometrist Optician

Signed _____ Date _____

Address _____ Telephone Number _____

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. 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 to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____