Manulife Financial

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.	Div. no	Certificate number/Social Insurance Number	Plan sponsor
84444			Toronto District School Board

Plan member name (first, middle initial, last) | Birthdate (dd/mmm/yyyy)

Plan member address (number, street and apt.) | City or town | Province | Postal code

* Please provide a mailing address for this claim.

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?
◯ 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.

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

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

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 From	To	Total dollar amount ($)

Additional child information

Complete only if patients listed above include dependent children.

Child's name	Student Yes	Student No	Handicapped Yes	Handicapped No	Name of School
	◯	◯	◯	◯	
	◯	◯	◯	◯	
	◯	◯	◯	◯	

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
P.O. BOX 1658
WATERLOO ON N2J 4W6