Form 408-1

HEALTH CARE/DRUG CLAIM FORM

THE Great-West Life ASSURANCE COMPANY

PLEASE SEE REVERSE FOR DETAILS ON HOW TO COMPLETE YOUR CLAIM FORM

PART I – MEMBER INFORMATION

Plan Name STF MEMBERS HEALTH PLAN Plan No. 51585

Member Name _____ Member Identification No. _____

Home Mailing Address _____
STREET CITY/TOWN PROVINCE POSTAL CODE

Phone Number _____ _____
HOME WORK

PART II – COORDINATION OF BENEFITS

Coordination of Benefits is a process used by the insurance industry to determine the order for payment of benefits when there is coverage provided under a spouse's or dependent's plan. Please note that a spouse who is covered under his/her employer's plan must first submit claims to that plan and a university student who is covered under a university plan must first submit claims to the university plan. Expenses for dependent children must first be submitted to the plan of the parent with the earlier birthdate in the year.

1. Are you, or any other member of your family, entitled to benefits under any other group plan? ❒ Yes ❒ No

   If "Yes", name of family member insured _____

   Relationship to STF Member _____

   Name of other insurance company _____

   Group Policy Number _____

2. Is your partner/spouse a teacher insured as a member under this plan? ❒ Yes ❒ No

   If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth | MM | DD |

3. Claims for members with a spouse/partner who is a teacher and who has coverage under another Great-West Life Policy or STF Members Health Plan may, by answering the question below, provide for automatic coordination of benefits.

   Do you want this claim automatically coordinated under your spouse/partner's plan? ❒ Yes ❒ No

   If "Yes", please provide your spouse's Employee or Member Identification Number

4. Is treatment required as the result of an accident? ❒ Yes ❒ No

   If "Yes", give date, location and explain how accident happened

5. Is a claim being made for Worker's Compensation Benefits? ❒ Yes ❒ No

Benefits are to be paid from: ❒ Health Care ❒ Drug

PART III – OTHER EXPENSES (EXCLUDING DRUGS)

Patient's Given Name	Relationship to Plan Member: Self	Spouse	Child	Date of Birth: DD	MM	YY	Children Only, check if: Full-Time University or College Student	Disabled	Type of Expense	Amount Charged for Each Expense
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
TOTAL OF OTHER EXPENSES →										$

PART IV – DRUG EXPENSES

Patient's Given Name	Relationship to Plan Member: Self	Spouse	Child	Date of Birth: DD	MM	YY	Children Only, check if: Full-Time University or College Student	Disabled	Number of Receipts Per Patient	Total Drug Amount Charged Per Patient
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
	❒	❒	❒				❒	❒		$
TOTAL OF DRUG EXPENSES →										$

MEMBER AUTHORIZATION

I certify that the statements in this claim are true and complete. I authorize release of any information or record requested in respect of this claim to the Saskatchewan Teachers' Federation, the STF Members Health Plan, Great-West Life and its claim agents, and any person or organization who has relevant personal information about me or my dependents, to exchange information for the purpose of payment of claims, underwriting or administration of the plan.

Member Signature _____ Date _____

SEE REVERSE

HOW TO SUBMIT YOUR CLAIM

1. Please complete one claim form for all family members for whom you are claiming expenses. You can also refer to the STF Website www.stf.sk.ca to find additional assistance in completing your form.
2. **Include your Member Identification Number on your claim form. It is the 10-digit number found on your prescription drug card, e.g., 0100000000. If you are a teacher on a temporary contract, you will not receive a prescription drug card. Your member identification number can be found on your confirmation of enrolment letter.**
3. Attach original, itemized bills and official receipts for income tax purposes for all expenses. **Staple receipts securely to back of claim form.** Photocopies (unless submitting for coordination of benefits), carbon copies, credit card receipts or cash register receipts are not acceptable. A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.
4. Bills and receipts are part of our records and will not be returned. Therefore, please retain copies of your receipts and the Explanation of Benefit that will accompany our cheque or explanation for your files and/or Income Tax purposes.
5. Mail your completed form, along with supporting documentation as described above, directly to the claims office as indicated below. You have **15 months** from the date your expense is incurred to submit for reimbursement.

COORDINATION OF BENEFITS

It is important that your plan pays only for benefits for which it is responsible. This is done through a process called Coordination of Benefits.

Coordination of Benefits is a group health insurance policy provision designed to eliminate duplicate payments and determine the order for payment of benefits when there is coverage provided under a spouse/partner's or dependent's group plan. This provision does not apply to individual health insurance plans. Benefit payments may be coordinated with the benefits provided by any other group plan to provide up to 100% of the eligible expenses, as long as the total amount received from all sources does not exceed the amount of the actual expenses incurred. A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.

A spouse/partner who is covered under his/her employer's group plan must first submit his/her claims to that plan and a university student who is covered under a university plan must first submit his/her claims to the university plan. Expenses for dependent children must first be submitted to the plan of the parent with the earlier birthday in the year. Part III question 1 helps us determine the order of payment. In situations where a child resides primarily with one parent, the order of benefit may change. Contact the claims office as indicated below.

OTHER EXPENSES

This section is to be completed when you have expenses for extended health care items, excluding vision care and drugs. Please provide the patient's name, the relationship to you, date of birth, status of child (if submitted claim is for a dependent child), the type of expense, e.g., massage therapy and the amount charged for each expense. Please provide the grand total of your other expenses in the bottom box of this section. (You must use the STF Members Health Plan Vision Care Claim Form when claiming reimbursement for vision care and supplies.)

DRUG EXPENSES

This section is to be completed when you have expenses for prescription drugs, excluding extended health care and vision expenses. Please provide the patient's name, the relationship to you, date of birth, status of child (if submitted claim is for a dependent child), the total number of receipts per patient and the total amount charged per patient. Please provide the grand total of your drug expenses in the bottom box of this section.

REMINDER

Coverage expenses and limitations apply to each individual covered family member. Frequency limitations and reasonable and customary charges may apply to extended health care charges. Certain items, e.g., private duty nursing, require preauthorization by Great-West Life prior to submission of your claim for reimbursement.

Please answer all questions and ensure your form is completed in full. This claim will be returned to you if it is incomplete, or contains errors, and will result in a delay in processing your claim. All claims under this group benefits plan must be submitted through, and signed by, the plan member.

WHERE TO SEND YOUR CLAIM

Send your claim to:

STF MEMBERS HEALTH PLAN
PO BOX 1944 STN MAIN
SASKATOON SK S7K 3S5

FOR CLAIM INQUIRIES, CALL
Toll Free: 1-800-667-7762
Phone: (306) 373-1660